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(Original Signature of Member)

108TH CONGRESS
1ST SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

M. introduced the following bill; which was referred to the Committee on

A BILL

To amend title XVIII of the Social Security Act to provide
for a voluntary program for prescription drug coverage
under the medicare program, to modernize the medicare
program, and for other purposes.

1 *Be it enacted by the Senate and House of Representatives*
2 *of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SE-**
4 **CURITY ACT; REFERENCES TO BIPA AND**
5 **SECRETARY; TABLE OF CONTENTS.**

6 (a) SHORT TITLE.—This Act may be cited as the “Medi-
7 care Prescription Drug and Modernization Act of 2003”.

1 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as
2 otherwise specifically provided, whenever in this Act an amend-
3 ment is expressed in terms of an amendment to or repeal of
4 a section or other provision, the reference shall be considered
5 to be made to that section or other provision of the Social Se-
6 curity Act.

7 (c) BIPA; SECRETARY.—In this Act:

8 (1) BIPA.—The term “BIPA” means the Medicare,
9 Medicaid, and SCHIP Benefits Improvement and Protec-
10 tion Act of 2000, as enacted into law by section 1(a)(6) of
11 Public Law 106–554.

12 (2) SECRETARY.—The term “Secretary” means the
13 Secretary of Health and Human Services.

14 (d) TABLE OF CONTENTS.—The table of contents of this
15 Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA
and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Establishment of a medicare prescription drug benefit.

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

“Sec. 1860D–1. Benefits; eligibility; enrollment; and coverage period.

“Sec. 1860D–2. Requirements for qualified prescription drug coverage.

“Sec. 1860D–3. Beneficiary protections for qualified prescription drug
coverage.

“Sec. 1860D–4. Requirements for and contracts with prescription drug
plan (PDP) sponsors.

“Sec. 1860D–5. Process for beneficiaries to select qualified prescription
drug coverage.

“Sec. 1860D–6. Submission of bids and premiums.

“Sec. 1860D–7. Premium and cost-sharing subsidies for low-income in-
dividuals.

“Sec. 1860D–8. Subsidies for all medicare beneficiaries for qualified
prescription drug coverage.

“Sec. 1860D–9. Medicare Prescription Drug Trust Fund.

“Sec. 1860D–10. Definitions; application to medicare advantage and
EFFS programs; treatment of references to provisions in part
C.

Sec. 102. Offering of qualified prescription drug coverage under Medicare
Advantage and enhanced fee-for-service (EFFS) program.

Sec. 103. Medicaid amendments.

“Sec. 1935. Special provisions relating to medicare prescription drug ben-
efit.

Sec. 104. Medigap transition.

Sec. 105. Medicare prescription drug discount card endorsement program.

Sec. 106. Disclosure of return information for purposes of carrying out
medicare catastrophic prescription drug program.

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Sec. 107. State pharmaceutical assistance transition commission.

**TITLE II—MEDICARE ENHANCED FEE-FOR-SERVICE AND
MEDICARE ADVANTAGE PROGRAMS; MEDICARE COMPETITION**

Sec. 200. Medicare modernization and revitalization.

Subtitle A—Medicare Enhanced Fee-for-Service Program

Sec. 201. Establishment of enhanced fee-for-service (EFTS) program under medicare.

“PART E—ENHANCED FEE-FOR-SERVICE PROGRAM

“Sec. 1860E–1. Offering of enhanced fee-for-service plans throughout the United States.

“Sec. 1860E–2. Offering of enhanced fee-for-service (EFTS) plans.

“Sec. 1860E–3. Submission of bids; beneficiary savings; payment of plans.

“Sec. 1860E–4. Premiums; organizational and financial requirements; establishment of standards; contracts with EFTS organizations.

Subtitle B—Medicare Advantage Program

CHAPTER 1—IMPLEMENTATION OF PROGRAM

Sec. 211. Implementation of medicare advantage program.

Sec. 212. Medicare advantage improvements.

CHAPTER 2—IMPLEMENTATION OF COMPETITION PROGRAM

Sec. 221. Competition program beginning in 2006.

CHAPTER 3—ADDITIONAL REFORMS

Sec. 231. Making permanent change in medicare advantage reporting deadlines and annual, coordinated election period.

Sec. 232. Avoiding duplicative State regulation.

Sec. 233. Specialized medicare advantage plans for special needs beneficiaries.

Sec. 234. Medicare MSAs.

Sec. 235. Extension of reasonable cost contracts.

Subtitle C—Application of FEHBP-Style Competitive Reforms

Sec. 241. Application of FEHBP-style competitive reform beginning in 2010.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

Sec. 301. Medicare secondary payor (MSP) provisions.

Sec. 302. Competitive acquisition of certain items and services.

Sec. 303. Competitive acquisition of covered outpatient drugs and biologicals.

Sec. 304. Demonstration project for use of recovery audit contractors.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

Sec. 401. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.

Sec. 402. Immediate establishment of uniform standardized amount in rural and small urban areas.

Sec. 403. Establishment of essential rural hospital classification.

Sec. 404. More frequent update in weights used in hospital market basket.

Sec. 405. Improvements to critical access hospital program.

Sec. 406. Redistribution of unused resident positions.

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- Sec. 407. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under prospective payment system for hospital outpatient department services.
- Sec. 408. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for skilled nursing facilities.
- Sec. 409. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
- Sec. 410. Improvement in payments to retain emergency capacity for ambulance services in rural areas.
- Sec. 411. One-year increase for home health services furnished in a rural area.
- Sec. 412. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
- Sec. 413. GAO study of geographic differences in payments for physicians' services.
- Sec. 414. Treatment of missing cost reporting periods for sole community hospitals.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

- Sec. 501. Revision of acute care hospital payment updates.
- Sec. 502. Recognition of new medical technologies under inpatient hospital PPS.
- Sec. 503. Increase in Federal rate for hospitals in Puerto Rico.
- Sec. 504. Wage index adjustment reclassification reform .
- Sec. 505. MedPAC report on specialty hospitals.

Subtitle B—Other Provisions

- Sec. 511. Payment for covered skilled nursing facility services.
- Sec. 512. Coverage of hospice consultation services.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

- Sec. 601. Revision of updates for physicians' services.
- Sec. 602. Studies on access to physicians' services.
- Sec. 603. MedPAC report on payment for physicians' services.

SUBTITLE B—PREVENTIVE SERVICES

- Sec. 611. Coverage of an initial preventive physical examination.
- Sec. 612. Coverage of cholesterol and blood lipid screening.
- Sec. 613. Waiver of deductible for colorectal cancer screening tests.
- Sec. 614. Improved payment for certain mammography services.

Subtitle C—Other Services

- Sec. 621. Hospital outpatient department (HOPD) payment reform.
- Sec. 622. Payment for ambulance services.
- Sec. 623. Renal dialysis services.
- Sec. 624. One-year moratorium on therapy caps; provisions relating to reports.
- Sec. 625. Adjustment to payments for services furnished in ambulatory surgical centers.
- Sec. 626. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
- Sec. 627. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 628. Part B deductible.

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TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 701. Update in home health services.
- Sec. 702. Establishment of reduced copayment for a home health service episode of care for certain beneficiaries.
- Sec. 703. MedPAC study on medicare margins of home health agencies.

Subtitle B—Direct Graduate Medical Education

- Sec. 711. Extension of update limitation on high cost programs.

Subtitle C—Chronic Care Improvement

- Sec. 721. Voluntary chronic care improvement under traditional fee-for-service.
- Sec. 722. Chronic care improvement under medicare advantage and enhanced fee-for-service programs.
- Sec. 723. Institute of Medicine report.
- Sec. 724. MedPAC report.

Subtitle D—Other Provisions

- Sec. 731. Modifications to medicare payment advisory commission (MedPAC).
- Sec. 732. Demonstration project for medical adult day care services.
- Sec. 723. Improvements in national and local coverage determination process to respond to changes in technology.
- Sec. 724. Treatment of certain physician pathology services.

TITLE VIII—MEDICARE BENEFITS ADMINISTRATION

- Sec. 801. Establishment of Medicare Benefits Administration.

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

- Sec. 901. Construction; definition of supplier.

“Supplier

- Sec. 902. Issuance of regulations.
- Sec. 903. Compliance with changes in regulations and policies.
- Sec. 904. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

- Sec. 911. Increased flexibility in medicare administration.
- Sec. 912. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

- Sec. 921. Provider education and technical assistance.
- “Sec. 1889. Provider education and technical assistance.
- Sec. 922. Small provider technical assistance demonstration program.
- Sec. 923. Medicare Provider Ombudsman; Medicare Beneficiary Ombudsman.
- Sec. 924. Beneficiary outreach demonstration program.
- Sec. 925. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
- Sec. 926. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery

- Sec. 931. Transfer of responsibility for medicare appeals.
- Sec. 932. Process for expedited access to review.

- Sec. 933. Revisions to medicare appeals process.
- Sec. 934. Prepayment review.
- Sec. 935. Recovery of overpayments.
- Sec. 936. Provider enrollment process; right of appeal.
- Sec. 937. Process for correction of minor errors and omissions without pursuing appeals process.
- Sec. 938. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle V—Miscellaneous Provisions

- Sec. 941. Policy development regarding evaluation and management (E & M) documentation guidelines.
- Sec. 942. Improvement in oversight of technology and coverage.
- Sec. 943. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
- Sec. 944. EMTALA improvements.
- Sec. 945. Emergency Medical Treatment and Active Labor Act (EMTALA) technical advisory group.
- Sec. 946. Authorizing use of arrangements to provide core hospice services in certain circumstances.
- Sec. 947. Application of osha bloodborne pathogens standard to certain hospitals.
- Sec. 948. BIPA-related technical amendments and corrections.
- Sec. 949. Conforming authority to waive a program exclusion.
- Sec. 950. Treatment of certain dental claims.
- Sec. 951. Furnishing hospitals with information to compute dsh formula.
- Sec. 952. Revisions to reassignment provisions.
- Sec. 953. Other provisions.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII is amended—

(1) by redesignating part D as part F; and

(2) by inserting after part C the following new part:

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT
PROGRAM

“SEC. 1860D–1. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

“(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860D–2(a)) as follows:

“(1) MEDICARE-RELATED PLANS.—

1 “(A) MEDICARE ADVANTAGE.—If the individual is
2 eligible to enroll in a Medicare Advantage plan that
3 provides qualified prescription drug coverage under sec-
4 tion 1851(j), the individual may enroll in such plan and
5 obtain coverage through such plan.

6 “(B) EFFS PLANS.—If the individual is eligible to
7 enroll in an EFFS plan that provides qualified pre-
8 scription drug coverage under part E under section
9 1860E–2(d), the individual may enroll in such plan and
10 obtain coverage through such plan.

11 “(C) MA-EFFS PLAN; MA-EFFS RX PLAN.—For
12 purposes of this part, the term ‘MA-EFFS plan’ means
13 a Medicare Advantage plan under part C and an EFFS
14 plan under part E and the term ‘MA-EFFS Rx plan’
15 means a MA-EFFS plan insofar as such plan provides
16 qualified prescription drug coverage.

17 “(2) PRESCRIPTION DRUG PLAN.—If the individual is
18 not enrolled in a MA-EFFS plan , the individual may en-
19 roll under this part in a prescription drug plan (as defined
20 in section 1860D–10(a)(5)).

21 Such individuals shall have a choice of such plans under section
22 1860D–5(d).

23 “(b) GENERAL ELECTION PROCEDURES.—

24 “(1) IN GENERAL.—An individual eligible to make an
25 election under subsection (a) may elect to enroll in a pre-
26 scription drug plan under this part, or elect the option of
27 qualified prescription drug coverage under a MA-EFFS Rx
28 plan under part C or part E, and to change such election
29 only in such manner and form as may be prescribed by reg-
30 ulations of the Administrator of the Medicare Benefits Ad-
31 ministration (appointed under section 1809(b)) (in this
32 part referred to as the ‘Medicare Benefits Administrator’)
33 and only during an election period prescribed in or under
34 this subsection.

35 “(2) ELECTION PERIODS.—

36 “(A) IN GENERAL.—Except as provided in this
37 paragraph, the election periods under this subsection

1 shall be the same as the coverage election periods
2 under the Medicare Advantage and EFFS programs
3 under section 1851(e), including—

4 “(i) annual coordinated election periods; and

5 “(ii) special election periods.

6 In applying the last sentence of section 1851(e)(4) (re-
7 lating to discontinuance of an election during the first
8 year of eligibility) under this subparagraph, in the case
9 of an election described in such section in which the in-
10 dividual had elected or is provided qualified prescrip-
11 tion drug coverage at the time of such first enrollment,
12 the individual shall be permitted to enroll in a prescrip-
13 tion drug plan under this part at the time of the elec-
14 tion of coverage under the original fee-for-service plan.

15 “(B) INITIAL ELECTION PERIODS.—

16 “(i) INDIVIDUALS CURRENTLY COVERED.—In
17 the case of an individual who is entitled to benefits
18 under part A or enrolled under part B as of No-
19 vember 1, 2005, there shall be an initial election
20 period of 6 months beginning on that date.

21 “(ii) INDIVIDUAL COVERED IN FUTURE.—In
22 the case of an individual who is first entitled to
23 benefits under part A or enrolled under part B
24 after such date, there shall be an initial election pe-
25 riod which is the same as the initial enrollment pe-
26 riod under section 1837(d).

27 “(C) ADDITIONAL SPECIAL ELECTION PERIODS.—

28 The Administrator shall establish special election
29 periods—

30 “(i) in cases of individuals who have and invol-
31 untarily lose prescription drug coverage described
32 in subsection (c)(2)(C);

33 “(ii) in cases described in section 1837(h) (re-
34 lating to errors in enrollment), in the same manner
35 as such section applies to part B;

36 “(iii) in the case of an individual who meets
37 such exceptional conditions (including conditions

provided under section 1851(e)(4)(D)) as the Administrator may provide; and

“(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

“(3) INFORMATION ON PLANS.—Information described in section 1860D–3(b)(1) on prescription drug plans shall be made available during election periods.

“(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

“(1) GUARANTEED ISSUE.—

“(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or MA-EFFS Rx plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

“(B) MEDICARE ADVANTAGE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

“(2) COMMUNITY-RATED PREMIUM.—

“(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous prescription drug coverage since the date the individual first qualifies to elect prescription drug coverage under this part, a PDP sponsor or entity offering a prescription drug plan or MA-EFFS Rx plan and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or vary or increase the premium under the plan based on any health status-re-

1 lated factor described in section 2702(a)(1) of the Pub-
2 lic Health Service Act or any other factor.

3 “(B) LATE ENROLLMENT PENALTY.—In the case
4 of an individual who does not maintain such continuous
5 prescription drug coverage (as described in subpara-
6 graph (C)), a PDP sponsor or an entity offering a MA-
7 EFFS Rx plan may (notwithstanding any provision in
8 this title) adjust the premium otherwise applicable or
9 impose a pre-existing condition exclusion with respect
10 to qualified prescription drug coverage in a manner
11 that reflects additional actuarial risk involved. Such a
12 risk shall be established through an appropriate actu-
13 arial opinion of the type described in subparagraphs
14 (A) through (C) of section 2103(c)(4).

15 “(C) CONTINUOUS PRESCRIPTION DRUG COV-
16 ERAGE.—An individual is considered for purposes of
17 this part to be maintaining continuous prescription
18 drug coverage on and after the date the individual first
19 qualifies to elect prescription drug coverage under this
20 part if the individual establishes that as of such date
21 the individual is covered under any of the following pre-
22 scription drug coverage and before the date that is the
23 last day of the 63-day period that begins on the date
24 of termination of the particular prescription drug cov-
25 erage involved (regardless of whether the individual
26 subsequently obtains any of the following prescription
27 drug coverage):

28 “(i) COVERAGE UNDER PRESCRIPTION DRUG
29 PLAN OR MA-EFFS RX PLAN.—Qualified prescrip-
30 tion drug coverage under a prescription drug plan
31 or under a MA-EFFS Rx plan.

32 “(ii) MEDICAID PRESCRIPTION DRUG COV-
33 ERAGE.—Prescription drug coverage under a med-
34 icaid plan under title XIX, including through the
35 Program of All-inclusive Care for the Elderly
36 (PACE) under section 1934, through a social
37 health maintenance organization (referred to in

1 section 4104(c) of the Balanced Budget Act of
2 1997), or through a demonstration project under
3 part C that demonstrates the application of capita-
4 tion payment rates for frail elderly medicare bene-
5 ficiaries through the use of an interdisciplinary
6 team and through the provision of primary care
7 services to such beneficiaries by means of such a
8 team at the nursing facility involved.

9 “(iii) PRESCRIPTION DRUG COVERAGE UNDER
10 GROUP HEALTH PLAN.—Any outpatient prescrip-
11 tion drug coverage under a group health plan, in-
12 cluding a health benefits plan under the Federal
13 Employees Health Benefit Plan under chapter 89
14 of title 5, United States Code, and a qualified re-
15 tiree prescription drug plan as defined in section
16 1860D–8(f)(1), but only if (subject to subpara-
17 graph (E)(ii)) the coverage provides benefits at
18 least equivalent to the benefits under a qualified
19 prescription drug plan.

20 “(iv) PRESCRIPTION DRUG COVERAGE UNDER
21 CERTAIN MEDIGAP POLICIES.—Coverage under a
22 medicare supplemental policy under section 1882
23 that provides benefits for prescription drugs
24 (whether or not such coverage conforms to the
25 standards for packages of benefits under section
26 1882(p)(1)), but only if the policy was in effect on
27 January 1, 2006, and if (subject to subparagraph
28 (E)(ii)) the coverage provides benefits at least
29 equivalent to the benefits under a qualified pre-
30 scription drug plan.

31 “(v) STATE PHARMACEUTICAL ASSISTANCE
32 PROGRAM.—Coverage of prescription drugs under a
33 State pharmaceutical assistance program, but only
34 if (subject to subparagraph (E)(ii)) the coverage
35 provides benefits at least equivalent to the benefits
36 under a qualified prescription drug plan.

1 “(vi) VETERANS’ COVERAGE OF PRESCRIPTION
2 DRUGS.—Coverage of prescription drugs for vet-
3 erans under chapter 17 of title 38, United States
4 Code, but only if (subject to subparagraph (E)(ii))
5 the coverage provides benefits at least equivalent to
6 the benefits under a qualified prescription drug
7 plan.

8 “(D) CERTIFICATION.—For purposes of carrying
9 out this paragraph, the certifications of the type de-
10 scribed in sections 2701(e) of the Public Health Service
11 Act and in section 9801(e) of the Internal Revenue
12 Code shall also include a statement for the period of
13 coverage of whether the individual involved had pre-
14 scription drug coverage described in subparagraph (C).

15 “(E) DISCLOSURE.—

16 “(i) IN GENERAL.—Each entity that offers
17 coverage of the type described in clause (iii), (iv),
18 (v), or (vi) of subparagraph (C) shall provide for
19 disclosure, consistent with standards established by
20 the Administrator, of whether such coverage pro-
21 vides benefits at least equivalent to the benefits
22 under a qualified prescription drug plan.

23 “(ii) WAIVER OF LIMITATIONS.—An individual
24 may apply to the Administrator to waive the re-
25 quirement that coverage of such type provide bene-
26 fits at least equivalent to the benefits under a
27 qualified prescription drug plan, if the individual
28 establishes that the individual was not adequately
29 informed that such coverage did not provide such
30 level of benefits.

31 “(F) CONSTRUCTION.—Nothing in this section
32 shall be construed as preventing the disenrollment of
33 an individual from a prescription drug plan or a MA-
34 EFFS Rx plan based on the termination of an election
35 described in section 1851(g)(3), including for non-pay-
36 ment of premiums or for other reasons specified in sub-

1 section (d)(3), which takes into account a grace period
2 described in section 1851(g)(3)(B)(i).

3 “(3) NONDISCRIMINATION.—A PDP sponsor that of-
4 fers a prescription drug plan in an area designated under
5 section 1860D–4(b)(5) shall make such plan available to all
6 eligible individuals residing in the area without regard to
7 their health or economic status or their place of residence
8 within the area.

9 “(d) EFFECTIVE DATE OF ELECTIONS.—

10 “(1) IN GENERAL.—Except as provided in this section,
11 the Administrator shall provide that elections under sub-
12 section (b) take effect at the same time as the Adminis-
13 trator provides that similar elections under section 1851(e)
14 take effect under section 1851(f).

15 “(2) NO ELECTION EFFECTIVE BEFORE 2006.—In no
16 case shall any election take effect before January 1, 2006.

17 “(3) TERMINATION.—The Administrator shall provide
18 for the termination of an election in the case of—

19 “(A) termination of coverage under both part A
20 and part B; and

21 “(B) termination of elections described in section
22 1851(g)(3) (including failure to pay required pre-
23 miums).

24 **“SEC. 1860D–2. REQUIREMENTS FOR QUALIFIED PRE-**
25 **SCRIPTION DRUG COVERAGE.**

26 “(a) REQUIREMENTS.—

27 “(1) IN GENERAL.—For purposes of this part and
28 part C and part E, the term ‘qualified prescription drug
29 coverage’ means either of the following:

30 “(A) STANDARD COVERAGE WITH ACCESS TO NE-
31 GOTIATED PRICES.—Standard coverage (as defined in
32 subsection (b)) and access to negotiated prices under
33 subsection (d).

34 “(B) ACTUARIALLY EQUIVALENT COVERAGE WITH
35 ACCESS TO NEGOTIATED PRICES.—Coverage of covered
36 outpatient drugs which meets the alternative coverage
37 requirements of subsection (c) and access to negotiated

1 prices under subsection (d), but only if it is approved
2 by the Administrator, as provided under subsection (c).

3 “(2) PERMITTING ADDITIONAL OUTPATIENT PRE-
4SCRIPTION DRUG COVERAGE.—

5 “(A) IN GENERAL.—Subject to subparagraph (B),
6 nothing in this part shall be construed as preventing
7 qualified prescription drug coverage from including cov-
8 erage of covered outpatient drugs that exceeds the cov-
9 erage required under paragraph (1), but any such addi-
10 tional coverage shall be limited to coverage of covered
11 outpatient drugs.

12 “(B) DISAPPROVAL AUTHORITY.—The Adminis-
13 trator shall review the offering of qualified prescription
14 drug coverage under this part or part C or E. If the
15 Administrator finds that, in the case of a qualified pre-
16 scription drug coverage under a prescription drug plan
17 or a MA-EFFS Rx plan, that the organization or spon-
18 sor offering the coverage is engaged in activities in-
19 tended to discourage enrollment of classes of eligible
20 medicare beneficiaries obtaining coverage through the
21 plan on the basis of their higher likelihood of utilizing
22 prescription drug coverage, the Administrator may ter-
23 minate the contract with the sponsor or organization
24 under this part or part C or E.

25 “(3) APPLICATION OF SECONDARY PAYOR PROVI-
26 SIONS.—The provisions of section 1852(a)(4) shall apply
27 under this part in the same manner as they apply under
28 part C.

29 “(b) STANDARD COVERAGE.—For purposes of this part,
30 the ‘standard coverage’ is coverage of covered outpatient drugs
31 (as defined in subsection (f)) that meets the following require-
32 ments:

33 “(1) DEDUCTIBLE.—The coverage has an annual
34 deductible—

35 “(A) for 2006, that is equal to \$250; or

36 “(B) for a subsequent year, that is equal to the
37 amount specified under this paragraph for the previous

1 year increased by the percentage specified in paragraph
2 (5) for the year involved.

3 Any amount determined under subparagraph (B) that is
4 not a multiple of \$10 shall be rounded to the nearest mul-
5 tiple of \$10.

6 “(2) 80:20 BENEFIT STRUCTURE.—

7 “(A) 20 PERCENT COPAYMENTS.—The coverage
8 has cost-sharing (for costs above the annual deductible
9 specified in paragraph (1) and up to the initial cov-
10 erage limit under paragraph (3)) that is—

11 “(i) equal to 20 percent; or

12 “(ii) is actuarially equivalent (using processes
13 established under subsection (e)) to an average ex-
14 pected payment of 20 percent of such costs.

15 “(B) USE OF TIERED COPAYMENTS.—Nothing in
16 this part shall be construed as preventing a PDP spon-
17 sor from applying tiered copayments, so long as such
18 tiered copayments are consistent with subparagraph
19 (A).

20 “(3) INITIAL COVERAGE LIMIT.—Subject to paragraph
21 (4), the coverage has an initial coverage limit on the max-
22 imum costs that may be recognized for payment
23 purposes—

24 “(A) for 2006, that is equal to \$2,000; or

25 “(B) for a subsequent year, that is equal to the
26 amount specified in this paragraph for the previous
27 year, increased by the annual percentage increase de-
28 scribed in paragraph (5) for the year involved.

29 Any amount determined under subparagraph (B) that is
30 not a multiple of \$25 shall be rounded to the nearest mul-
31 tiple of \$25.

32 “(4) CATASTROPHIC PROTECTION.—

33 “(A) IN GENERAL.—Notwithstanding paragraph
34 (3), the coverage provides benefits with no cost-sharing
35 after the individual has incurred costs (as described in
36 subparagraph (C)) for covered outpatient drugs in a

1 year equal to the annual out-of-pocket threshold speci-
2 fied in subparagraph (B).

3 “(B) ANNUAL OUT-OF-POCKET THRESHOLD.—

4 “(i) IN GENERAL.—For purposes of this part,
5 the ‘annual out-of-pocket threshold’ specified in
6 this subparagraph is equal to \$3,700 (subject to
7 adjustment under clause (ii) and subparagraph
8 (D)).

9 “(ii) INFLATION INCREASE.—For a year after
10 2006, the dollar amount specified in clause (i) shall
11 be increased by the annual percentage increase de-
12 scribed in paragraph (5) for the year involved. Any
13 amount determined under the previous sentence
14 that is not a multiple of \$100 shall be rounded to
15 the nearest multiple of \$100.

16 “(C) APPLICATION.—In applying subparagraph
17 (A)—

18 “(i) incurred costs shall only include costs in-
19 curred for the annual deductible (described in para-
20 graph (1)), cost-sharing (described in paragraph
21 (2)), and amounts for which benefits are not pro-
22 vided because of the application of the initial cov-
23 erage limit described in paragraph (3); and

24 “(ii) such costs shall be treated as incurred
25 only if they are paid by the individual (or by an-
26 other individual, such as a family member, on be-
27 half of the individual), under section 1860D-7, or
28 under title XIX and the individual (or other indi-
29 vidual) is not reimbursed through insurance or oth-
30 erwise, a group health plan, or other third-party
31 payment arrangement for such costs.

32 “(D) ADJUSTMENT OF ANNUAL OUT-OF-POCKET
33 THRESHOLDS.—

34 “(i) IN GENERAL.—For each enrollee in a pre-
35 scription drug plan or in a MA-EFFS Rx plan
36 whose adjusted gross income exceeds the income
37 threshold as defined in clause (ii) for a year, the

1 annual out-of-pocket threshold otherwise deter-
2 mined under subparagraph (B) for such year shall
3 be increased by an amount equal to the percentage
4 specified in clause (iii), multiplied by the lesser
5 of—

6 “(I) the amount of such excess; or

7 “(II) the amount by which the income
8 threshold limit exceeds the income threshold.

9 Any amount determined under the previous sen-
10 tence that is not a multiple of \$100 shall be round-
11 ed to the nearest multiple of \$100.

12 “(ii) INCOME THRESHOLD.—For purposes of
13 clause (i)—

14 “(I) IN GENERAL.—Subject to subclause
15 (II), the term ‘income threshold’ means
16 \$60,000 and the term ‘income threshold limit’
17 means \$200,000.

18 “(II) INCOME INFLATION ADJUSTMENT.—
19 In the case of a year beginning after 2006,
20 each of the dollar amounts in subclause (I)
21 shall be increased by an amount equal to such
22 dollar amount multiplied by the cost-of-living
23 adjustment determined under section 1(f)(3) of
24 the Internal Revenue Code of 1986 for such
25 year, determined by substituting ‘calendar year
26 2005’ for ‘calendar year 1992’. If any amount
27 increased under the previous sentence is not a
28 multiple of \$100, such amount shall be round-
29 ed to the nearest multiple of \$100.

30 “(iii) PERCENTAGE.—The percentage specified
31 in this clause for a year is a fraction (expressed as
32 a percentage) equal to—

33 “(I) the annual-of-out pocket threshold for
34 a year under subparagraph (B) (determined
35 without regard to this subparagraph), divided
36 by

1 “(II) the income threshold under clause
2 (ii) for that year.

3 If any percentage determined under the previous
4 sentence that is not a multiple of $\frac{1}{10}$ th of 1 per-
5 centage point, such percentage shall be rounded to
6 the nearest multiple of $\frac{1}{10}$ th of 1 percentage point.

7 “(iv) USE OF MOST RECENT RETURN INFOR-
8 MATION.—For purposes of clause (i) for an enrollee
9 for a year, except as provided in clause (v), the ad-
10 justed gross income of an individual shall be based
11 on the most recent information disclosed to the
12 Secretary under section 6109(l)(19) of the Internal
13 Revenue Code of 1986 before the beginning of that
14 year.

15 “(v) PROCESS FOR USE OF OTHER RETURN
16 INFORMATION.—The Secretary shall provide, in co-
17 ordination with the Secretary of the Treasury, a
18 procedure under which, for purposes of applying
19 this subparagraph for a calendar year, instead of
20 using the information described in clause (iv), an
21 enrollee may elect to use more recent information,
22 including information with respect to a taxable year
23 ending in such calendar year. Such process shall—

24 “(I) require the enrollee to provide the
25 Secretary with a copy of the relevant portion of
26 the more recent return to be used under this
27 clause;

28 “(II) provide for the verification of the in-
29 formation in such return by the Secretary of
30 the Treasury under section 6103(l)(19) of the
31 Internal Revenue Code of 1986; and

32 “(III) provide for the payment by the Sec-
33 retary (in a manner specified by the Secretary)
34 to the enrollee of an amount equal to the excess
35 of the benefit payments that would have been
36 payable under the plan if the more recent re-

1 turn information were used, over the benefit
2 payments that were made under the plan.

3 In the case of a payment under subclause (III) for
4 an enrollee under a prescription drug plan, the
5 PDP sponsor of the plan shall pay to the Secretary
6 the amount so paid, less the applicable reinsurance
7 amount that would have applied under section
8 1860D–8(c)(1)(B) if such payment had been treat-
9 ed as an allowable cost under such section. Such
10 plan payment shall be deposited in the Treasury to
11 the credit of the Medicare Prescription Drug Ac-
12 count in the Federal Supplementary Medical Insur-
13 ance Trust Fund (under section 1841).

14 “(vi) DISSEMINATION OF INFORMATION ON
15 PROCESS.—The Secretary shall provide, through
16 the annual medicare handbook under section
17 1804(a), for a general description of the adjust-
18 ment of annual out-of-pocket thresholds provided
19 under this subparagraph, including the process for
20 adjustment based upon more recent information
21 and the confidentiality provisions of subparagraph
22 (F), and shall provide for dissemination of a table
23 for each year that sets forth the amount of the ad-
24 justment that is made under clause (i) based on the
25 amount of an enrollee’s adjusted gross income.

26 “(E) REQUESTING INFORMATION ON ENROLL-
27 EES.—

28 “(i) IN GENERAL.—The Secretary shall, peri-
29 odically as required to carry out subparagraph (D),
30 transmit to the Secretary of the Treasury a list of
31 the names and TINs of enrollees in prescription
32 drug plans (or in MA-EFFS Rx plans) and request
33 that such Secretary disclose to the Secretary infor-
34 mation under subparagraph (A) of section
35 6103(l)(19) of the Internal Revenue Code of 1986
36 with respect to those enrollees for a specified tax-

1 able year for application in a particular calendar
2 year.

3 “(ii) DISCLOSURE TO PLAN SPONSORS.—In
4 the case of a specified taxpayer (as defined in sec-
5 tion 6103(l)(19)(B) of the Internal Revenue Code
6 of 1986) who is enrolled in a prescription drug plan
7 or in an MA-EFFS Rx plan, the Secretary shall
8 disclose to the entity that offers the plan the an-
9 nual out-of-pocket threshold applicable to such in-
10 dividual under subparagraph (D).

11 “(F) MAINTAINING CONFIDENTIALITY OF INFOR-
12 MATION.—

13 “(i) IN GENERAL.—The amount of any in-
14 crease in an annual out-of-pocket threshold under
15 subparagraph (D) may not be disclosed by the Sec-
16 retary except to a PDP sponsor or entity that of-
17 fers a MA-EFFS Rx plan to the extent necessary
18 to carry out this part.

19 “(ii) CRIMINAL AND CIVIL PENALTIES FOR UN-
20 AUTHORIZED DISCLOSURE.—A person who makes
21 an unauthorized disclosure of information disclosed
22 under section 6103(l)(19) of the Internal Revenue
23 Code of 1986 (including disclosure of any increase
24 in an annual out-of-pocket threshold under sub-
25 paragraph (D)) shall be subject to penalty to the
26 extent provided under—

27 “(I) section 7213 of such Code (relating to
28 criminal penalty for unauthorized disclosure of
29 information);

30 “(II) section 7213A of such Code (relating
31 to criminal penalty for unauthorized inspection
32 of returns or return information);

33 “(III) section 7431 of such Code (relating
34 to civil damages for unauthorized inspection or
35 disclosure of returns and return information);

36 “(IV) any other provision of the Internal
37 Revenue Code of 1986; or

1 “(V) any other provision of law.

2 “(iii) APPLICATION OF ADDITIONAL CIVIL
3 MONETARY PENALTY FOR UNAUTHORIZED DISCLO-
4 SURES.—In addition to any penalty otherwise pro-
5 vided under law, any person who makes an unau-
6 thorized disclosure of such information shall be
7 subject to a civil monetary penalty of not to exceed
8 \$10,000 for each such unauthorized disclosure. The
9 provisions of section 1128A (other than subsections
10 (a) and (b)) shall apply to civil money penalties
11 under this subparagraph in the same manner as
12 they apply to a penalty or proceeding under section
13 1128A(a).

14 “(5) ANNUAL PERCENTAGE INCREASE.—For purposes
15 of this part, the annual percentage increase specified in
16 this paragraph for a year is equal to the annual percentage
17 increase in average per capita aggregate expenditures for
18 covered outpatient drugs in the United States for medicare
19 beneficiaries, as determined by the Administrator for the
20 12-month period ending in July of the previous year.

21 “(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A pre-
22 scription drug plan or MA-EFFS Rx plan may provide a dif-
23 ferent prescription drug benefit design from the standard cov-
24 erage described in subsection (b) so long as the Administrator
25 determines (based on an actuarial analysis by the Adminis-
26 trator) that the following requirements are met and the plan
27 applies for, and receives, the approval of the Administrator for
28 such benefit design:

29 “(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT
30 COVERAGE.—

31 “(A) ASSURING EQUIVALENT VALUE OF TOTAL
32 COVERAGE.—The actuarial value of the total coverage
33 (as determined under subsection (e)) is at least equal
34 to the actuarial value (as so determined) of standard
35 coverage.

36 “(B) ASSURING EQUIVALENT UNSUBSIDIZED
37 VALUE OF COVERAGE.—The unsubsidized value of the

1 coverage is at least equal to the unsubsidized value of
2 standard coverage. For purposes of this subparagraph,
3 the unsubsidized value of coverage is the amount by
4 which the actuarial value of the coverage (as deter-
5 mined under subsection (e)) exceeds the actuarial value
6 of the subsidy payments under section 1860D–8 with
7 respect to such coverage.

8 “(C) ASSURING STANDARD PAYMENT FOR COSTS
9 AT INITIAL COVERAGE LIMIT.—The coverage is de-
10 signed, based upon an actuarially representative pat-
11 tern of utilization (as determined under subsection (e)),
12 to provide for the payment, with respect to costs in-
13 curred that are equal to the initial coverage limit under
14 subsection (b)(3), of an amount equal to at least the
15 product of—

16 “(i) the amount by which the initial coverage
17 limit described in subsection (b)(3) exceeds the de-
18 ductible described in subsection (b)(1); and

19 “(ii) 100 percent minus the cost-sharing per-
20 centage specified in subsection (b)(2)(A)(i).

21 “(2) CATASTROPHIC PROTECTION.—The coverage pro-
22 vides for beneficiaries the catastrophic protection described
23 in subsection (b)(4).

24 “(d) ACCESS TO NEGOTIATED PRICES.—

25 “(1) IN GENERAL.—Under qualified prescription drug
26 coverage offered by a PDP sponsor or an entity offering a
27 MA-EFFS Rx plan, the sponsor or entity shall provide
28 beneficiaries with access to negotiated prices (including ap-
29 plicable discounts) used for payment for covered outpatient
30 drugs, regardless of the fact that no benefits may be pay-
31 able under the coverage with respect to such drugs because
32 of the application of cost-sharing or an initial coverage
33 limit (described in subsection (b)(3)). Insofar as a State
34 elects to provide medical assistance under title XIX for a
35 drug based on the prices negotiated by a prescription drug
36 plan under this part, the requirements of section 1927 shall
37 not apply to such drugs. The prices negotiated by a pre-

1 scription drug plan under this part, by a MA-EFFS Rx
2 plan with respect to covered outpatient drugs, or by a
3 qualified retiree prescription drug plan (as defined in sec-
4 tion 1860D–8(f)(1)) with respect to such drugs on behalf
5 of individuals entitled to benefits under part A or enrolled
6 under part B, shall (notwithstanding any other provision of
7 law) not be taken into account for the purposes of estab-
8 lishing the best price under section 1927(c)(1)(C).

9 “(2) DISCLOSURE.—The PDP sponsor or entity offer-
10 ing a MA-EFFS Rx plan shall disclose to the Adminis-
11 trator (in a manner specified by the Administrator) the ex-
12 tent to which discounts or rebates or other remuneration
13 or price concessions made available to the sponsor or orga-
14 nization by a manufacturer are passed through to enrollees
15 through pharmacies and other dispensers or otherwise. The
16 provisions of section 1927(b)(3)(D) shall apply to informa-
17 tion disclosed to the Administrator under this paragraph in
18 the same manner as such provisions apply to information
19 disclosed under such section.

20 “(3) AUDITS AND REPORTS.—To protect against fraud
21 and abuse and to ensure proper disclosures and accounting
22 under this part, in addition to any protections against
23 fraud and abuse provided under section 1860D–4(b)(3)(C),
24 the Administrator may periodically audit the financial
25 statements and records of PDP sponsor or entities offering
26 a MA-EFFS Rx plan.

27 “(e) ACTUARIAL VALUATION; DETERMINATION OF AN-
28 NUAL PERCENTAGE INCREASES.—

29 “(1) PROCESSES.—For purposes of this section, the
30 Administrator shall establish processes and methods—

31 “(A) for determining the actuarial valuation of
32 prescription drug coverage, including—

33 “(i) an actuarial valuation of standard cov-
34 erage and of the reinsurance subsidy payments
35 under section 1860D–8;

36 “(ii) the use of generally accepted actuarial
37 principles and methodologies; and

1 “(iii) applying the same methodology for de-
2 terminations of alternative coverage under sub-
3 section (c) as is used with respect to determina-
4 tions of standard coverage under subsection (b);
5 and

6 “(B) for determining annual percentage increases
7 described in subsection (b)(5).

8 “(2) USE OF OUTSIDE ACTUARIES.—Under the proc-
9 esses under paragraph (1)(A), PDP sponsors and entities
10 offering MA-EFFS Rx plans may use actuarial opinions
11 certified by independent, qualified actuaries to establish ac-
12 tuarial values, but the Administrator shall determine
13 whether such actuarial values meet the requirements under
14 subsection (c)(1).

15 “(f) COVERED OUTPATIENT DRUGS DEFINED.—

16 “(1) IN GENERAL.—Except as provided in this sub-
17 section, for purposes of this part, the term ‘covered out-
18 patient drug’ means—

19 “(A) a drug that may be dispensed only upon a
20 prescription and that is described in subparagraph
21 (A)(i) or (A)(ii) of section 1927(k)(2); or

22 “(B) a biological product described in clauses (i)
23 through (iii) of subparagraph (B) of such section or in-
24 sulin described in subparagraph (C) of such section,
25 and such term includes a vaccine licensed under section
26 351 of the Public Health Service Act and any use of a cov-
27 ered outpatient drug for a medically accepted indication (as
28 defined in section 1927(k)(6)).

29 “(2) EXCLUSIONS.—

30 “(A) IN GENERAL.—Such term does not include
31 drugs or classes of drugs, or their medical uses, which
32 may be excluded from coverage or otherwise restricted
33 under section 1927(d)(2), other than subparagraph (E)
34 thereof (relating to smoking cessation agents), or under
35 section 1927(d)(3).

36 “(B) AVOIDANCE OF DUPLICATE COVERAGE.—A
37 drug prescribed for an individual that would otherwise

1 be a covered outpatient drug under this part shall not
2 be so considered if payment for such drug is available
3 under part A or B for an individual entitled to benefits
4 under part A and enrolled under part B.

5 “(3) APPLICATION OF FORMULARY RESTRICTIONS.—A
6 drug prescribed for an individual that would otherwise be
7 a covered outpatient drug under this part shall not be so
8 considered under a plan if the plan excludes the drug under
9 a formulary and such exclusion is not successfully appealed
10 under section 1860D–3(f)(2).

11 “(4) APPLICATION OF GENERAL EXCLUSION PROVI-
12 SIONS.—A prescription drug plan or MA-EFFS Rx plan
13 may exclude from qualified prescription drug coverage any
14 covered outpatient drug—

15 “(A) for which payment would not be made if sec-
16 tion 1862(a) applied to part D; or

17 “(B) which are not prescribed in accordance with
18 the plan or this part.

19 Such exclusions are determinations subject to reconsider-
20 ation and appeal pursuant to section 1860D–3(f).

21 **“SEC. 1860D–3. BENEFICIARY PROTECTIONS FOR QUALI-**
22 **FIED PRESCRIPTION DRUG COVERAGE.**

23 “(a) GUARANTEED ISSUE, COMMUNITY-RATED PREMIUMS,
24 ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—
25 For provisions requiring guaranteed issue, community-rated
26 premiums, access to negotiated prices, and nondiscrimination,
27 see sections 1860D–1(c)(1), 1860D–1(c)(2), 1860D–2(d), and
28 1860D–6(b), respectively.

29 “(b) DISSEMINATION OF INFORMATION.—

30 “(1) GENERAL INFORMATION.—A PDP sponsor shall
31 disclose, in a clear, accurate, and standardized form to
32 each enrollee with a prescription drug plan offered by the
33 sponsor under this part at the time of enrollment and at
34 least annually thereafter, the information described in sec-
35 tion 1852(c)(1) relating to such plan. Such information in-
36 cludes the following:

1 “(A) Access to covered outpatient drugs, including
2 access through pharmacy networks.

3 “(B) How any formulary used by the sponsor
4 functions, including the drugs included in the for-
5 mulary.

6 “(C) Co-payments and deductible requirements,
7 including the identification of the tiered or other co-
8 payment level applicable to each drug (or class of
9 drugs).

10 “(D) Grievance and appeals procedures.

11 Such information shall also be made available upon request
12 to prospective enrollees.

13 “(2) DISCLOSURE UPON REQUEST OF GENERAL COV-
14 ERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—
15 Upon request of an individual eligible to enroll under a pre-
16 scription drug plan, the PDP sponsor shall provide the in-
17 formation described in section 1852(c)(2) (other than sub-
18 paragraph (D)) to such individual.

19 “(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each
20 PDP sponsor offering a prescription drug plan shall have
21 a mechanism for providing specific information to enrollees
22 upon request. The sponsor shall make available on a timely
23 basis, through an Internet website and in writing upon re-
24 quest, information on specific changes in its formulary.

25 “(4) CLAIMS INFORMATION.—Each PDP sponsor of-
26 fering a prescription drug plan must furnish to each en-
27 rollee in a form easily understandable to such enrollees an
28 explanation of benefits (in accordance with section 1806(a)
29 or in a comparable manner) and a notice of the benefits
30 in relation to initial coverage limit and the annual out-of-
31 pocket threshold applicable to such enrollee for the current
32 year, whenever prescription drug benefits are provided
33 under this part (except that such notice need not be pro-
34 vided more often than monthly).

35 “(c) ACCESS TO COVERED BENEFITS.—

36 “(1) ASSURING PHARMACY ACCESS.—

37 “(A) SECURING SUFFICIENT PARTICIPATION.—

1 “(i) PARTICIPATION OF ANY WILLING PHAR-
2 MACY.—A PDP sponsor and an entity offering a
3 MA-EFFS Rx plan shall permit the participation
4 of any pharmacy that meets terms and conditions
5 that the plan has established.

6 “(ii) DISCOUNTS ALLOWED FOR NETWORK
7 PHARMACIES.—A prescription drug plan and a MA-
8 EFFS Rx plan may, notwithstanding clause (i), re-
9 duce copayments for its enrolled beneficiaries below
10 the level otherwise provided for covered outpatient
11 drugs dispensed through in-network pharmacies,
12 but in no case shall such a reduction result in an
13 increase in payments made by the Administrator
14 under section 1860D–8 to a plan.

15 “(iii) CONVENIENT ACCESS FOR NETWORK
16 PHARMACIES.—The PDP sponsor of the prescrip-
17 tion drug plan and the entity offering a MA-EFFS
18 Rx plan shall secure the participation in its net-
19 work of a sufficient number of pharmacies that dis-
20 pense (other than by mail order) drugs directly to
21 patients to ensure convenient access (consistent
22 with rules of the Administrator established under
23 subparagraph (B)). The Administrator shall estab-
24 lish convenient access rules under this clause that
25 are no less favorable to enrollees than the rules for
26 convenient access to pharmacies of the Secretary of
27 Defense established as of June 1, 2003, for pur-
28 poses of the TRICARE Retail Pharmacy (TRRx)
29 program. Such rules shall include adequate emer-
30 gency access for enrolled beneficiaries.

31 “(iv) LEVEL PLAYING FIELD.—Such a sponsor
32 shall permit enrollees to receive benefits (which
33 may include a 90-day supply of drugs or
34 biologicals) through a community pharmacy, rather
35 than through mail order, with any differential in
36 cost paid by such enrollees.

1 “(v) NOT REQUIRED TO ACCEPT INSURANCE
2 RISK.—The terms and conditions under clause (i)
3 may not require participating pharmacies to accept
4 insurance risk as a condition of participation.

5 “(2) USE OF STANDARDIZED TECHNOLOGY.—

6 “(A) IN GENERAL.—The PDP sponsor of a pre-
7 scription drug plan and an entity offering a MA-EFFS
8 Rx plan shall issue (and reissue, as appropriate) such
9 a card (or other technology) that may be used by an
10 enrollee to assure access to negotiated prices under sec-
11 tion 1860D–2(d) for the purchase of prescription drugs
12 for which coverage is not otherwise provided under the
13 plan.

14 “(B) STANDARDS.—

15 “(i) DEVELOPMENT.—The Administrator shall
16 provide for the development or utilization of uni-
17 form standards relating to a standardized format
18 for the card or other technology referred to in sub-
19 paragraph (A). Such standards shall be compatible
20 with standards established under part C of title XI.

21 “(ii) APPLICATION OF ADVISORY TASK
22 FORCE.—The advisory task force established under
23 subsection (d)(3)(B)(ii) shall provide recommenda-
24 tions to the Administrator under such subsection
25 regarding the standards developed under clause (i).

26 “(3) REQUIREMENTS ON DEVELOPMENT AND APPLICA-
27 TION OF FORMULARIES.—If a PDP sponsor of a prescrip-
28 tion drug plan or an entity offering a MA-EFFS Rx plan
29 uses a formulary, the following requirements must be met:

30 “(A) PHARMACY AND THERAPEUTIC (P&T) COM-
31 MITTEE.—The sponsor or entity must establish a phar-
32 macy and therapeutic committee that develops and re-
33 views the formulary. Such committee shall include at
34 least one practicing physician and at least one prac-
35 ticing pharmacist both with expertise in the care of el-
36 derly or disabled persons and a majority of its members

1 shall consist of individuals who are practicing physi-
2 cians or practicing pharmacists (or both).

3 “(B) FORMULARY DEVELOPMENT.—In developing
4 and reviewing the formulary, the committee shall—

5 “(i) base clinical decisions on the strength of
6 scientific evidence and standards of practice, in-
7 cluding assessing peer-reviewed medical literature,
8 such as randomized clinical trials,
9 pharmacoeconomic studies, outcomes research data,
10 and such other information as the committee deter-
11 mines to be appropriate; and

12 “(ii) shall take into account whether including
13 in the formulary particular covered outpatient
14 drugs has therapeutic advantages in terms of safety
15 and efficacy.

16 “(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC
17 CATEGORIES.—The formulary must include drugs with-
18 in each therapeutic category and class of covered out-
19 patient drugs (although not necessarily for all drugs
20 within such categories and classes). In establishing
21 such classes, the committee shall take into account the
22 standards published in the United States Pharma-
23 copeia-Drug Information. The committee shall make
24 available to the enrollees under the plan through the
25 Internet or otherwise the clinical bases for the coverage
26 of any drug on the formulary.

27 “(D) PROVIDER AND PATIENT EDUCATION.—The
28 committee shall establish policies and procedures to
29 educate and inform health care providers and enrollees
30 concerning the formulary.

31 “(E) NOTICE BEFORE REMOVING DRUGS FROM
32 FORMULARY.—Any removal of a drug from a formulary
33 shall take effect only after appropriate notice is made
34 available to beneficiaries and physicians.

35 “(F) PERIODIC EVALUATION OF PROTOCOLS.—In
36 connection with the formulary, a prescription drug plan

1 shall provide for the periodic evaluation and analysis of
2 treatment protocols and procedures.

3 “(G) GRIEVANCES AND APPEALS RELATING TO AP-
4 PPLICATION OF FORMULARIES.—For provisions relating
5 to grievances and appeals of coverage, see subsections
6 (e) and (f).

7 “(d) COST AND UTILIZATION MANAGEMENT; QUALITY AS-
8 SURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

9 “(1) IN GENERAL.—The PDP sponsor or entity offer-
10 ing a MA-EFFS Rx plan shall have in place, directly or
11 through appropriate arrangements, with respect to covered
12 outpatient drugs—

13 “(A) an effective cost and drug utilization man-
14 agement program, including medically appropriate in-
15 centives to use generic drugs and therapeutic inter-
16 change, when appropriate;

17 “(B) quality assurance measures and systems to
18 reduce medical errors and adverse drug interactions
19 and improve medication use, including a medication
20 therapy management program described in paragraph
21 (2) and for years beginning with 2007, an electronic
22 prescription program described in paragraph (3); and

23 “(C) a program to control fraud, abuse, and
24 waste.

25 Nothing in this section shall be construed as impairing a
26 PDP sponsor or entity from utilizing cost management
27 tools (including differential payments) under all methods of
28 operation.

29 “(2) MEDICATION THERAPY MANAGEMENT PRO-
30 GRAM.—

31 “(A) IN GENERAL.—A medication therapy man-
32 agement program described in this paragraph is a pro-
33 gram of drug therapy management and medication ad-
34 ministration that may be furnished by a pharmacy pro-
35 vider and that is designed to assure, with respect to
36 beneficiaries at risk for potential medication problems,
37 such as beneficiaries with complex or chronic diseases

(such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use and reduce the risk of adverse events, including adverse drug interactions. Such programs may distinguish between services in ambulatory and institutional settings.

“(B) ELEMENTS.—Such program may include—

“(i) enhanced beneficiary understanding to promote the appropriate use of medications by beneficiaries and to reduce the risk of potential adverse events associated with medications, through beneficiary education, counseling, case management, disease state management programs, and other appropriate means;

“(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other compliance programs and other appropriate means; and

“(iii) detection of patterns of overuse and underuse of prescription drugs.

“(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

“(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program and an entity offering a MA-EFFS Rx plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program. Each such sponsor or entity shall disclose to the Administrator upon request the amount of any such management or dispensing fees.

“(3) ELECTRONIC PRESCRIPTION PROGRAM.—

1 “(A) IN GENERAL.—An electronic prescription
2 drug program described in this paragraph is a program
3 that includes at least the following components, con-
4 sistent with uniform standards established under sub-
5 paragraph (B):

6 “(i) ELECTRONIC TRANSMITTAL OF PRESCRIP-
7 TIONS.—Prescriptions must be written and trans-
8 mitted electronically (other than by facsimile), ex-
9 cept in emergency cases and other exceptional cir-
10 cumstances recognized by the Administrator.

11 “(ii) PROVISION OF INFORMATION TO PRE-
12 SCRIBING HEALTH CARE PROFESSIONAL.—The pro-
13 gram provides for the electronic transmittal to the
14 prescribing health care professional of information
15 that includes—

16 “(I) information (to the extent available
17 and feasible) on the drug or drugs being pre-
18 scribed for that patient and other information
19 relating to the medical history or condition of
20 the patient that may be relevant to the appro-
21 priate prescription for that patient;

22 “(II) cost-effective alternatives (if any) for
23 the use of the drug prescribed; and

24 “(III) information on the drugs included
25 in the applicable formulary.

26 To the extent feasible, such program shall permit
27 the prescribing health care professional to provide
28 (and be provided) related information on an inter-
29 active, real-time basis.

30 “(B) STANDARDS.—

31 “(i) DEVELOPMENT.—The Administrator shall
32 provide for the development of uniform standards
33 relating to the electronic prescription drug program
34 described in subparagraph (A). Such standards
35 shall be compatible with standards established
36 under part C of title XI.

1 “(ii) ADVISORY TASK FORCE.—In developing
2 such standards and the standards described in sub-
3 section (c)(2)(B)(i) the Administrator shall estab-
4 lish a task force that includes representatives of
5 physicians, hospitals, pharmacies, beneficiaries,
6 pharmacy benefit managers, individuals with exper-
7 tise in information technology, and pharmacy ben-
8 efit experts of the Departments of Veterans Affairs
9 and Defense and other appropriate Federal agen-
10 cies to provide recommendations to the Adminis-
11 trator on such standards, including recommenda-
12 tions relating to the following:

13 “(I) The range of available computerized
14 prescribing software and hardware and their
15 costs to develop and implement.

16 “(II) The extent to which such standards
17 and systems reduce medication errors and can
18 be readily implemented by physicians, phar-
19 macies, and hospitals.

20 “(III) Efforts to develop uniform stand-
21 ards and a common software platform for the
22 secure electronic communication of medication
23 history, eligibility, benefit, and prescription in-
24 formation.

25 “(IV) Efforts to develop and promote uni-
26 versal connectivity and interoperability for the
27 secure electronic exchange of such information.

28 “(V) The cost of implementing such sys-
29 tems in the range of hospital and physician of-
30 fice settings and pharmacies, including hard-
31 ware, software, and training costs.

32 “(VI) Implementation issues as they relate
33 to part C of title XI, and current Federal and
34 State prescribing laws and regulations and
35 their impact on implementation of computer-
36 ized prescribing.

37 “(iii) DEADLINES.—

1 “(I) The Administrator shall constitute
2 the task force under clause (ii) by not later
3 than April 1, 2004.

4 “(II) Such task force shall submit rec-
5 ommendations to Administrator by not later
6 than January 1, 2005.

7 “(III) The Administrator shall provide for
8 the development and promulgation, by not later
9 than January 1, 2006, of national standards
10 relating to the electronic prescription drug pro-
11 gram described in clause (ii). Such standards
12 shall be issued by a standards organization ac-
13 credited by the American National Standards
14 Institute (ANSI) and shall be compatible with
15 standards established under part C of title XI.

16 “(4) TREATMENT OF ACCREDITATION.—Section
17 1852(e)(4) (relating to treatment of accreditation) shall
18 apply to prescription drug plans under this part with re-
19 spect to the following requirements, in the same manner as
20 they apply to plans under part C with respect to the re-
21 quirements described in a clause of section 1852(e)(4)(B):

22 “(A) Paragraph (1) (including quality assurance),
23 including medication therapy management program
24 under paragraph (2).

25 “(B) Subsection (c)(1) (relating to access to cov-
26 ered benefits).

27 “(C) Subsection (g) (relating to confidentiality and
28 accuracy of enrollee records).

29 “(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL
30 PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor and
31 each entity offering a MA-EFFS Rx plan shall provide that
32 each pharmacy or other dispenser that arranges for the dis-
33 pensing of a covered outpatient drug shall inform the bene-
34 ficiary at the time of purchase of the drug of any differen-
35 tial between the price of the prescribed drug to the enrollee
36 and the price of the lowest cost available generic drug cov-

1 ered under the plan that is therapeutically equivalent and
2 bioequivalent.

3 “(e) GRIEVANCE MECHANISM, COVERAGE DETERMINA-
4 TIONS, AND RECONSIDERATIONS.—

5 “(1) IN GENERAL.—Each PDP sponsor shall provide
6 meaningful procedures for hearing and resolving grievances
7 between the organization (including any entity or individual
8 through which the sponsor provides covered benefits) and
9 enrollees with prescription drug plans of the sponsor under
10 this part in accordance with section 1852(f).

11 “(2) APPLICATION OF COVERAGE DETERMINATION
12 AND RECONSIDERATION PROVISIONS.—A PDP sponsor
13 shall meet the requirements of paragraphs (1) through (3)
14 of section 1852(g) with respect to covered benefits under
15 the prescription drug plan it offers under this part in the
16 same manner as such requirements apply to an organiza-
17 tion with respect to benefits it offers under a plan under
18 part C.

19 “(3) REQUEST FOR REVIEW OF TIERED FORMULARY
20 DETERMINATIONS.—In the case of a prescription drug plan
21 offered by a PDP sponsor or a MA-EFFS Rx plan that
22 provides for tiered cost-sharing for drugs included within a
23 formulary and provides lower cost-sharing for preferred
24 drugs included within the formulary, an individual who is
25 enrolled in the plan may request coverage of a nonpreferred
26 drug under the terms applicable for preferred drugs if the
27 prescribing physician determines that the preferred drug
28 for treatment of the same condition either would not be as
29 effective for the individual or would have adverse effects for
30 the individual or both.

31 “(f) APPEALS.—

32 “(1) IN GENERAL.—Subject to paragraph (2), a PDP
33 sponsor shall meet the requirements of paragraphs (4) and
34 (5) of section 1852(g) with respect to drugs not included
35 on any formulary in the same manner as such requirements
36 apply to an organization with respect to benefits it offers
37 under a plan under part C.

1 “(2) FORMULARY DETERMINATIONS.—An individual
2 who is enrolled in a prescription drug plan offered by a
3 PDP sponsor or in a MA-EFFS Rx plan may appeal to ob-
4 tain coverage for a covered outpatient drug that is not on
5 a formulary of the sponsor or entity offering the plan if the
6 prescribing physician determines that the formulary drug
7 for treatment of the same condition either would not be as
8 effective for the individual or would have adverse effects for
9 the individual or both.

10 “(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE
11 RECORDS.—A PDP sponsor that offers a prescription drug
12 plan shall meet the requirements of section 1852(h) with re-
13 spect to enrollees under the plan in the same manner as such
14 requirements apply to an organization with respect to enrollees
15 under part C.

16 **“SEC. 1860D-4. REQUIREMENTS FOR AND CONTRACTS**
17 **WITH PRESCRIPTION DRUG PLAN (PDP)**
18 **SPONSORS.**

19 “(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a
20 prescription drug plan shall meet the following requirements:

21 “(1) LICENSURE.—Subject to subsection (c), the spon-
22 sor is organized and licensed under State law as a risk-
23 bearing entity eligible to offer health insurance or health
24 benefits coverage in each State in which it offers a pre-
25 scription drug plan.

26 “(2) ASSUMPTION OF FINANCIAL RISK FOR UNSUB-
27 SIDIZED COVERAGE.—

28 “(A) IN GENERAL.—Subject to subparagraph (B)
29 and section 1860D-5(d)(2), the entity assumes full fi-
30 nancial risk on a prospective basis for qualified pre-
31 scription drug coverage that it offers under a prescrip-
32 tion drug plan and that is not covered under section
33 1860D-8.

34 “(B) REINSURANCE PERMITTED.—The entity may
35 obtain insurance or make other arrangements for the
36 cost of coverage provided to any enrollee.

1 “(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the
2 case of a sponsor that is not described in paragraph (1),
3 the sponsor shall meet solvency standards established by
4 the Administrator under subsection (d).

5 “(b) CONTRACT REQUIREMENTS.—

6 “(1) IN GENERAL.—The Administrator shall not per-
7 mit the election under section 1860D–1 of a prescription
8 drug plan offered by a PDP sponsor under this part, and
9 the sponsor shall not be eligible for payments under section
10 1860D–7 or 1860D–8, unless the Administrator has en-
11 tered into a contract under this subsection with the sponsor
12 with respect to the offering of such plan. Such a contract
13 with a sponsor may cover more than one prescription drug
14 plan. Such contract shall provide that the sponsor agrees
15 to comply with the applicable requirements and standards
16 of this part and the terms and conditions of payment as
17 provided for in this part.

18 “(2) NEGOTIATION REGARDING TERMS AND CONDI-
19 TIONS.—The Administrator shall have the same authority
20 to negotiate the terms and conditions of prescription drug
21 plans under this part as the Director of the Office of Per-
22 sonnel Management has with respect to health benefits
23 plans under chapter 89 of title 5, United States Code. In
24 negotiating the terms and conditions regarding premiums
25 for which information is submitted under section 1860D–
26 6(a)(2), the Administrator shall take into account the sub-
27 sidy payments under section 1860D–8.

28 “(3) INCORPORATION OF CERTAIN MEDICARE ADVAN-
29 TAGE CONTRACT REQUIREMENTS.—The following provi-
30 sions of section 1857 shall apply, subject to subsection
31 (c)(5), to contracts under this section in the same manner
32 as they apply to contracts under section 1857(a):

33 “(A) MINIMUM ENROLLMENT.—Paragraphs (1)
34 and (3) of section 1857(b).

35 “(B) CONTRACT PERIOD AND EFFECTIVENESS.—
36 Paragraphs (1) through (3) and (5) of section 1857(c).

1 “(C) PROTECTIONS AGAINST FRAUD AND BENE-
2 FICIARY PROTECTIONS.—Section 1857(d).

3 “(D) ADDITIONAL CONTRACT TERMS.—Section
4 1857(e); except that in applying section 1857(e)(2)
5 under this part—

6 “(i) such section shall be applied separately to
7 costs relating to this part (from costs under part
8 C);

9 “(ii) in no case shall the amount of the fee es-
10 tablished under this subparagraph for a plan ex-
11 ceed 20 percent of the maximum amount of the fee
12 that may be established under subparagraph (B) of
13 such section; and

14 “(iii) no fees shall be applied under this sub-
15 paragraph with respect to Medicare Advantage
16 plans.

17 “(E) INTERMEDIATE SANCTIONS.—Section
18 1857(g).

19 “(F) PROCEDURES FOR TERMINATION.—Section
20 1857(h).

21 “(4) RULES OF APPLICATION FOR INTERMEDIATE
22 SANCTIONS.—In applying paragraph (3)(E)—

23 “(A) the reference in section 1857(g)(1)(B) to sec-
24 tion 1854 is deemed a reference to this part; and

25 “(B) the reference in section 1857(g)(1)(F) to sec-
26 tion 1852(k)(2)(A)(ii) shall not be applied.

27 “(5) SERVICE AREA REQUIREMENT.—For purposes of
28 this part, the Administrator shall designate at least 10
29 areas covering the entire United States.

30 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND
31 CHOICE.—

32 “(1) IN GENERAL.—In the case of an entity that seeks
33 to offer a prescription drug plan in a State, the Adminis-
34 trator shall waive the requirement of subsection (a)(1) that
35 the entity be licensed in that State if the Administrator de-
36 termines, based on the application and other evidence pre-
37 sented to the Administrator, that any of the grounds for

1 approval of the application described in paragraph (2) has
2 been met.

3 “(2) GROUNDS FOR APPROVAL.—The grounds for ap-
4 proval under this paragraph are the grounds for approval
5 described in subparagraph (B), (C), and (D) of section
6 1855(a)(2), and also include the application by a State of
7 any grounds other than those required under Federal law.

8 “(3) APPLICATION OF WAIVER PROCEDURES.—With
9 respect to an application for a waiver (or a waiver granted)
10 under this subsection, the provisions of subparagraphs (E),
11 (F), and (G) of section 1855(a)(2) shall apply.

12 “(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CON-
13 STITUTE CERTIFICATION.—The fact that an entity is li-
14 censed in accordance with subsection (a)(1) does not deem
15 the entity to meet other requirements imposed under this
16 part for a PDP sponsor.

17 “(5) REFERENCES TO CERTAIN PROVISIONS.—For
18 purposes of this subsection, in applying provisions of sec-
19 tion 1855(a)(2) under this subsection to prescription drug
20 plans and PDP sponsors—

21 “(A) any reference to a waiver application under
22 section 1855 shall be treated as a reference to a waiver
23 application under paragraph (1); and

24 “(B) any reference to solvency standards shall be
25 treated as a reference to solvency standards established
26 under subsection (d).

27 “(d) SOLVENCY STANDARDS FOR NON-LICENSED SPON-
28 SORS.—

29 “(1) ESTABLISHMENT.—The Administrator shall es-
30 tablish, by not later than October 1, 2004, financial sol-
31 vency and capital adequacy standards that an entity that
32 does not meet the requirements of subsection (a)(1) must
33 meet to qualify as a PDP sponsor under this part.

34 “(2) COMPLIANCE WITH STANDARDS.—Each PDP
35 sponsor that is not licensed by a State under subsection
36 (a)(1) and for which a waiver application has been ap-
37 proved under subsection (c) shall meet solvency and capital

1 adequacy standards established under paragraph (1). The
2 Administrator shall establish certification procedures for
3 such PDP sponsors with respect to such solvency standards
4 in the manner described in section 1855(c)(2).

5 “(e) RELATION TO STATE LAWS.—

6 “(1) IN GENERAL.—The standards established under
7 this part shall supersede any State law or regulation (other
8 than State licensing laws or State laws relating to plan sol-
9 vency, except as provided in subsection (d)) with respect to
10 prescription drug plans which are offered by PDP sponsors
11 under this part.

12 “(2) PROHIBITION OF STATE IMPOSITION OF PREMIUM
13 TAXES.—No State may impose a premium tax or similar
14 tax with respect to premiums paid to PDP sponsors for
15 prescription drug plans under this part, or with respect to
16 any payments made to such a sponsor by the Administrator
17 under this part.

18 **“SEC. 1860D-5. PROCESS FOR BENEFICIARIES TO SE-**
19 **LECT QUALIFIED PRESCRIPTION DRUG COV-**
20 **ERAGE.**

21 “(a) IN GENERAL.—The Administrator shall establish a
22 process for the selection of the prescription drug plan or MA-
23 EFFS Rx plan through which eligible individuals elect qualified
24 prescription drug coverage under this part.

25 “(b) ELEMENTS.—Such process shall include the fol-
26 lowing:

27 “(1) Annual, coordinated election periods, in which
28 such individuals can change the qualifying plans through
29 which they obtain coverage, in accordance with section
30 1860D-1(b)(2).

31 “(2) Active dissemination of information to promote
32 an informed selection among qualifying plans based upon
33 price, quality, and other features, in the manner described
34 in (and in coordination with) section 1851(d), including the
35 provision of annual comparative information, maintenance
36 of a toll-free hotline, and the use of non-Federal entities.

1 “(3) Coordination of elections through filing with the
2 entity offering a MA-EFFS Rx plan or a PDP sponsor, in
3 the manner described in (and in coordination with) section
4 1851(c)(2).

5 “(4) Informing each enrollee before the beginning of
6 each year of the annual out-of-pocket threshold applicable
7 to the enrollee for that year under section 1860D–2(b)(4)
8 at such time.

9 “(c) MA-EFFS RX ENROLLEE MAY ONLY OBTAIN BENE-
10 FITS THROUGH THE PLAN.—An individual who is enrolled
11 under a MA-EFFS Rx plan may only elect to receive qualified
12 prescription drug coverage under this part through such plan.

13 “(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRE-
14 SCRIPTION DRUG COVERAGE.—

15 “(1) CHOICE OF AT LEAST TWO PLANS IN EACH
16 AREA.—

17 “(A) IN GENERAL.—The Administrator shall as-
18 sure that each individual who is entitled to benefits
19 under part A or enrolled under part B and who is re-
20 siding in an area in the United States has available,
21 consistent with subparagraph (B), a choice of enroll-
22 ment in at least two qualifying plans (as defined in
23 paragraph (5)) in the area in which the individual re-
24 sides, at least one of which is a prescription drug plan.

25 “(B) REQUIREMENT FOR DIFFERENT PLAN SPON-
26 SORS.—The requirement in subparagraph (A) is not
27 satisfied with respect to an area if only one PDP spon-
28 sor or one entity that offers a MA-EFFS Rx plan of-
29 fers all the qualifying plans in the area.

30 “(2) GUARANTEEING ACCESS TO COVERAGE.—In order
31 to assure access under paragraph (1) and consistent with
32 paragraph (3), the Administrator may provide partial un-
33 derwriting of risk for a PDP sponsor to expand the service
34 area under an existing prescription drug plan to adjoining
35 or additional areas or to establish such a plan (including
36 offering such a plan on a regional or nationwide basis), but

1 only so long as (and to the extent) necessary to assure the
2 access guaranteed under paragraph (1).

3 “(3) LIMITATION ON AUTHORITY.—In exercising au-
4 thority under this subsection, the Administrator—

5 “(A) shall not provide for the full underwriting of
6 financial risk for any PDP sponsor; and

7 “(B) shall seek to maximize the assumption of fi-
8 nancial risk by PDP sponsors or entities offering a
9 MA-EFFS Rx plan.

10 “(4) REPORTS.—The Administrator shall, in each an-
11 nual report to Congress under section 1809(f), include in-
12 formation on the exercise of authority under this sub-
13 section. The Administrator also shall include such rec-
14 ommendations as may be appropriate to minimize the exer-
15 cise of such authority, including minimizing the assumption
16 of financial risk.

17 “(5) QUALIFYING PLAN DEFINED.—For purposes of
18 this subsection, the term ‘qualifying plan’ means a pre-
19 scription drug plan or a MA-EFFS Rx plan.

20 **“SEC. 1860D-6. SUBMISSION OF BIDS AND PREMIUMS.**

21 “(a) SUBMISSION OF BIDS, PREMIUMS, AND RELATED IN-
22 FORMATION.—

23 “(1) IN GENERAL.—Each PDP sponsor shall submit
24 to the Administrator the information described in para-
25 graph (2) in the same manner as information is submitted
26 by an organization under section 1854(a)(1).

27 “(2) INFORMATION SUBMITTED.—The information de-
28 scribed in this paragraph is the following:

29 “(A) COVERAGE PROVIDED.—Information on the
30 qualified prescription drug coverage to be provided.

31 “(B) ACTUARIAL VALUE.—Information on the ac-
32 tuarial value of the coverage.

33 “(C) BID AND PREMIUM.—Information on the bid
34 and the premium for the coverage, including an actu-
35 arial certification of—

36 “(i) the actuarial basis for such bid and pre-
37 mium;

1 “(ii) the portion of such bid and premium at-
2 tributable to benefits in excess of standard cov-
3 erage;

4 “(iii) the reduction in such bid resulting from
5 the reinsurance subsidy payments provided under
6 section 1860D–8(a)(2); and

7 “(iv) the reduction in such premium resulting
8 from the direct and reinsurance subsidy payments
9 provided under section 1860D–8.

10 “(D) ADDITIONAL INFORMATION.—Such other in-
11 formation as the Administrator may require to carry
12 out this part.

13 “(3) REVIEW OF INFORMATION; NEGOTIATION AND
14 APPROVAL OF PREMIUMS.—

15 “(A) IN GENERAL.—Subject to subparagraph (B),
16 the Administrator shall review the information filed
17 under paragraph (2) for the purpose of conducting ne-
18 gotiations under section 1860D–4(b)(2) (relating to
19 using OPM-like authority under the FEHBP). The Ad-
20 ministrator, using the information provided (including
21 the actuarial certification under paragraph (2)(C))
22 shall approve the premium submitted under this sub-
23 section only if the premium accurately reflects both (i)
24 the actuarial value of the benefits provided, and (ii) the
25 72 percent average subsidy provided under section
26 1860D–8 for the standard benefit. The Administrator
27 shall apply actuarial principles to approval of a pre-
28 mium under this part in a manner similar to the man-
29 ner in which those principles are applied in establishing
30 the monthly part B premium under section 1839.

31 “(B) EXCEPTION.—In the case of a plan described
32 in section 1851(a)(2)(C), the provisions of subpara-
33 graph (A) shall not apply and the provisions of para-
34 graph (5)(B), prohibiting the review, approval, or dis-
35 approval of amounts described in such paragraph, shall
36 apply to the negotiation and rejection of the monthly

1 bid amounts and proportion referred to in subpara-
2 graph (A).

3 “(b) UNIFORM BID AND PREMIUM.—

4 “(1) IN GENERAL.—The bid and premium for a pre-
5 scription drug plan under this section may not vary among
6 enrollees in the plan in the same service area.

7 “(2) CONSTRUCTION.—Nothing in paragraph (1) shall
8 be construed as preventing the imposition of a late enroll-
9 ment penalty under section 1860D–1(c)(2)(B).

10 “(c) COLLECTION.—

11 “(1) BENEFICIARY’S OPTION OF PAYMENT THROUGH
12 WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE
13 OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In ac-
14 cordance with regulations, a PDP sponsor shall permit
15 each enrollee, at the enrollee’s option, to make payment of
16 premiums under this part to the sponsor through with-
17 holding from benefit payments in the manner provided
18 under section 1840 with respect to monthly premiums
19 under section 1839 or through an electronic funds transfer
20 mechanism (such as automatic charges of an account at a
21 financial institution or a credit or debit card account) or
22 otherwise. All premium payments under this paragraph
23 shall be credited to the Medicare Prescription Drug Trust
24 Fund.

25 “(2) OFFSETTING.—Reductions in premiums for cov-
26 erage under parts A and B as a result of a selection of a
27 Medicare Advantage plan may be used to reduce the pre-
28 mium otherwise imposed under paragraph (1).

29 “(d) ACCEPTANCE OF REFERENCE PREMIUM AMOUNT AS
30 FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVIDUALS
31 IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

32 “(1) IN GENERAL.—If there is no standard prescrip-
33 tion drug coverage (as defined in paragraph (2)) offered in
34 an area, in the case of an individual who is eligible for a
35 premium subsidy under section 1860D–7 and resides in the
36 area, the PDP sponsor of any prescription drug plan of-
37 fered in the area (and any entity offering a MA-EFFS Rx

1 plan in the area) shall accept the reference premium
2 amount (under paragraph (3)) as payment in full for the
3 premium charge for qualified prescription drug coverage.

4 “(2) STANDARD PRESCRIPTION DRUG COVERAGE DE-
5 FINED.—For purposes of this subsection, the term ‘stand-
6 ard prescription drug coverage’ means qualified prescrip-
7 tion drug coverage that is standard coverage or that has
8 an actuarial value equivalent to the actuarial value for
9 standard coverage.

10 “(3) REFERENCE PREMIUM AMOUNT DEFINED.—For
11 purposes of this subsection, the term ‘reference premium
12 amount’ means, with respect to qualified prescription drug
13 coverage offered under—

14 “(A) a prescription drug plan that—

15 “(i) provides standard coverage (or alternative
16 prescription drug coverage the actuarial value is
17 equivalent to that of standard coverage), the plan’s
18 PDP premium; or

19 “(ii) provides alternative prescription drug
20 coverage the actuarial value of which is greater
21 than that of standard coverage, the plan’s PDP
22 premium multiplied by the ratio of (I) the actuarial
23 value of standard coverage, to (II) the actuarial
24 value of the alternative coverage;

25 “(B) an EFFS plan, the EFFS monthly prescrip-
26 tion drug beneficiary premium (as defined in section
27 1860E–4(a)(3)(B)); or

28 “(C) a Medicare Advantage, the Medicare Advan-
29 tage monthly prescription drug beneficiary premium (as
30 defined in section 1854(b)(2)(B)).

31 For purposes of subparagraph (A), the term ‘PDP pre-
32 mium’ means, with respect to a prescription drug plan, the
33 premium amount for enrollment under the plan under this
34 part (determined without regard to any low-income subsidy
35 under section 1860D–7 or any late enrollment penalty
36 under section 1860D–1(c)(2)(B)).

1 **“SEC. 1860D-7. PREMIUM AND COST-SHARING SUBSIDIES**
2 **FOR LOW-INCOME INDIVIDUALS.**

3 “(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS
4 WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY
5 LEVEL.—

6 “(1) FULL PREMIUM SUBSIDY AND REDUCTION OF
7 COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135
8 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a
9 subsidy eligible individual (as defined in paragraph (4))
10 who is determined to have income that does not exceed 135
11 percent of the Federal poverty level, the individual is enti-
12 tled under this section—

13 “(A) to an income-related premium subsidy equal
14 to 100 percent of the amount described in subsection
15 (b)(1); and

16 “(B) subject to subsection (c), to the substitution
17 for the beneficiary cost-sharing described in paragraphs
18 (1) and (2) of section 1860D-2(b) (up to the initial
19 coverage limit specified in paragraph (3) of such sec-
20 tion) of amounts that do not exceed \$2 for a multiple
21 source or generic drug (as described in section
22 1927(k)(7)(A)) and \$5 for a non-preferred drug.

23 “(2) SLIDING SCALE PREMIUM SUBSIDY FOR INDIVID-
24 UALS WITH INCOME ABOVE 135, BUT BELOW 150 PERCENT,
25 OF FEDERAL POVERTY LEVEL.—In the case of a subsidy el-
26 igible individual who is determined to have income that ex-
27 ceeds 135 percent, but does not exceed 150 percent, of the
28 Federal poverty level, the individual is entitled under this
29 section to an income-related premium subsidy determined
30 on a linear sliding scale ranging from 100 percent of the
31 amount described in subsection (b)(1) for individuals with
32 incomes at 135 percent of such level to 0 percent of such
33 amount for individuals with incomes at 150 percent of such
34 level.

35 “(3) CONSTRUCTION.—Nothing in this section shall be
36 construed as preventing a PDP sponsor or entity offering

1 a MA-EFFS Rx plan from reducing to 0 the cost-sharing
2 otherwise applicable to generic drugs.

3 “(4) DETERMINATION OF ELIGIBILITY.—

4 “(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—

5 For purposes of this section, subject to subparagraph
6 (D), the term ‘subsidy eligible individual’ means an in-
7 dividual who—

8 “(i) is eligible to elect, and has elected, to ob-
9 tain qualified prescription drug coverage under this
10 part;

11 “(ii) has income below 150 percent of the Fed-
12 eral poverty line; and

13 “(iii) meets the resources requirement de-
14 scribed in section 1905(p)(1)(C).

15 “(B) DETERMINATIONS.—The determination of
16 whether an individual residing in a State is a subsidy
17 eligible individual and the amount of such individual’s
18 income shall be determined under the State medicaid
19 plan for the State under section 1935(a) or by the So-
20 cial Security Administration. In the case of a State
21 that does not operate such a medicaid plan (either
22 under title XIX or under a statewide waiver granted
23 under section 1115), such determination shall be made
24 under arrangements made by the Administrator. There
25 are authorized to be appropriated to the Social Security
26 Administration such sums as may be necessary for the
27 determination of eligibility under this subparagraph.

28 “(C) INCOME DETERMINATIONS.—For purposes of
29 applying this section—

30 “(i) income shall be determined in the manner
31 described in section 1905(p)(1)(B); and

32 “(ii) the term ‘Federal poverty line’ means the
33 official poverty line (as defined by the Office of
34 Management and Budget, and revised annually in
35 accordance with section 673(2) of the Omnibus
36 Budget Reconciliation Act of 1981) applicable to a
37 family of the size involved.

1 “(D) TREATMENT OF TERRITORIAL RESIDENTS.—

2 In the case of an individual who is not a resident of
3 the 50 States or the District of Columbia, the indi-
4 vidual is not eligible to be a subsidy eligible individual
5 but may be eligible for financial assistance with pre-
6 scription drug expenses under section 1935(e).

7 “(E) TREATMENT OF CONFORMING MEDIGAP
8 POLICIES.—For purposes of this section, the term
9 ‘qualified prescription drug coverage’ includes a medi-
10 care supplemental policy described in section 1860D-
11 8(b)(4).

12 “(5) INDEXING DOLLAR AMOUNTS.—

13 “(A) FOR 2007.—The dollar amounts applied
14 under paragraphs (1)(B) for 2007 shall be the dollar
15 amounts specified in such paragraph increased by the
16 annual percentage increase described in section
17 1860D-2(b)(5) for 2007.

18 “(B) FOR SUBSEQUENT YEARS.—The dollar
19 amounts applied under paragraph (1)(B) for a year
20 after 2007 shall be the amounts (under this paragraph)
21 applied under paragraph (1)(B) for the preceding year
22 increased by the annual percentage increase described
23 in section 1860D-2(b)(5) (relating to growth in medi-
24 care prescription drug costs per beneficiary) for the
25 year involved.

26 “(b) PREMIUM SUBSIDY AMOUNT.—

27 “(1) IN GENERAL.—The premium subsidy amount de-
28 scribed in this subsection for an individual residing in an
29 area is the benchmark premium amount (as defined in
30 paragraph (2)) for qualified prescription drug coverage of-
31 fered by the prescription drug plan or the MA-EFFS Rx
32 plan in which the individual is enrolled.

33 “(2) BENCHMARK PREMIUM AMOUNT DEFINED.—For
34 purposes of this subsection, the term ‘benchmark premium
35 amount’ means, with respect to qualified prescription drug
36 coverage offered under—

37 “(A) a prescription drug plan that—

1 “(i) provides standard coverage (or alternative
2 prescription drug coverage the actuarial value is
3 equivalent to that of standard coverage), the pre-
4 mium amount for enrollment under the plan under
5 this part (determined without regard to any sub-
6 sidy under this section or any late enrollment pen-
7 alty under section 1860D–1(c)(2)(B)); or

8 “(ii) provides alternative prescription drug
9 coverage the actuarial value of which is greater
10 than that of standard coverage, the premium
11 amount described in clause (i) multiplied by the
12 ratio of (I) the actuarial value of standard cov-
13 erage, to (II) the actuarial value of the alternative
14 coverage; or

15 “(B) a MA-EFFS Rx plan, the portion of the pre-
16 mium amount that is attributable to statutory drug
17 benefits (described in section 1853(a)(1)(A)(ii)(II)).

18 “(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

19 “(1) IN GENERAL.—In applying subsection (a)(1)(B),
20 nothing in this part shall be construed as preventing a plan
21 or provider from waiving or reducing the amount of cost-
22 sharing otherwise applicable.

23 “(2) LIMITATION ON CHARGES.—In the case of an in-
24 dividual receiving cost-sharing subsidies under subsection
25 (a)(1)(B), the PDP sponsor or entity offering a MA-EFFS
26 Rx plan may not charge more than \$5 per prescription.

27 “(3) APPLICATION OF INDEXING RULES.—The provi-
28 sions of subsection (a)(5) shall apply to the dollar amount
29 specified in paragraph (2) in the same manner as they
30 apply to the dollar amounts specified in subsections
31 (a)(1)(B).

32 “(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Ad-
33 ministrator shall provide a process whereby, in the case of an
34 individual who is determined to be a subsidy eligible individual
35 and who is enrolled in prescription drug plan or is enrolled in
36 a MA-EFFS Rx plan—

1 “(1) the Administrator provides for a notification of
2 the PDP sponsor or the entity offering the MA-EFFS Rx
3 plan involved that the individual is eligible for a subsidy
4 and the amount of the subsidy under subsection (a);

5 “(2) the sponsor or entity involved reduces the pre-
6 miums or cost-sharing otherwise imposed by the amount of
7 the applicable subsidy and submits to the Administrator in-
8 formation on the amount of such reduction; and

9 “(3) the Administrator periodically and on a timely
10 basis reimburses the sponsor or entity for the amount of
11 such reductions.

12 The reimbursement under paragraph (3) with respect to cost-
13 sharing subsidies may be computed on a capitated basis, taking
14 into account the actuarial value of the subsidies and with ap-
15 propriate adjustments to reflect differences in the risks actually
16 involved.

17 “(e) RELATION TO MEDICAID PROGRAM.—

18 “(1) IN GENERAL.—For provisions providing for eligi-
19 bility determinations, and additional financing, under the
20 medicaid program, see section 1935.

21 “(2) MEDICAID PROVIDING WRAP AROUND BENE-
22 FITS.—The coverage provided under this part is primary
23 payor to benefits for prescribed drugs provided under the
24 medicaid program under title XIX consistent with section
25 1935(d)(1).

26 “(3) COORDINATION.—The Administrator shall de-
27 velop and implement a plan for the coordination of pre-
28 scription drug benefits under this part with the benefits
29 provided under the medicaid program under title XIX, with
30 particular attention to insuring coordination of payments
31 and prevention of fraud and abuse. In developing and im-
32 plementing such plan, the Administrator shall involve the
33 Secretary, the States, the data processing industry, phar-
34 macists, and pharmaceutical manufacturers, and other ex-
35 perts.

1 **“SEC. 1860D–8. SUBSIDIES FOR ALL MEDICARE BENE-**
2 **FICIARIES FOR QUALIFIED PRESCRIPTION**
3 **DRUG COVERAGE.**

4 “(a) SUBSIDY PAYMENT.—In order to reduce premium
5 levels applicable to qualified prescription drug coverage for all
6 medicare beneficiaries consistent with an overall subsidy level
7 of 72 percent, to reduce adverse selection among prescription
8 drug plans and MA-EFFS Rx plans, and to promote the par-
9 ticipation of PDP sponsors under this part, the Administrator
10 shall provide in accordance with this section for payment to a
11 qualifying entity (as defined in subsection (b)) of the following
12 subsidies:

13 “(1) DIRECT SUBSIDY.—In the case of an enrollee en-
14 rolled for a month in a prescription drug plan or a MA-
15 EFFS Rx plan, a direct subsidy equal to 42 percent of the
16 national average monthly bid amount (computed under sub-
17 section (g)) for that month.

18 “(2) SUBSIDY THROUGH REINSURANCE.—In the case
19 of an enrollee enrolled for a month in a prescription drug
20 plan or a MA-EFFS Rx plan, the reinsurance payment
21 amount (as defined in subsection (c)), which in the aggre-
22 gate is 30 percent of the total payments made by qualifying
23 entities for standard coverage under the respective plan, for
24 excess costs incurred in providing qualified prescription
25 drug coverage—

26 “(A) for enrollees with a prescription drug plan
27 under this part; and

28 “(B) for enrollees with a MA-EFFS Rx plan.

29 “(3) EMPLOYER AND UNION FLEXIBILITY.—In the
30 case of an individual who is a participant or beneficiary in
31 a qualified retiree prescription drug plan (as defined in
32 subsection (f)(1)) and who is not enrolled in a prescription
33 drug plan or in a MA-EFFS Rx plan, the special subsidy
34 payments under subsection (f)(3).

35 This section constitutes budget authority in advance of appro-
36 priations Acts and represents the obligation of the Adminis-
37 trator to provide for the payment of amounts provided under

1 this section. In applying the percentages under paragraphs (1)
2 and (2), there shall be taken into account under the respective
3 paragraphs the portion of the employer and union special sub-
4 sidy payments under subsection (f)(3) that reflect payments
5 that would have been made under the respective paragraphs if
6 such paragraphs had applied to qualified retiree prescription
7 drug plans instead of paragraph (3).

8 “(b) QUALIFYING ENTITY DEFINED.—For purposes of
9 this section, the term ‘qualifying entity’ means any of the fol-
10 lowing that has entered into an agreement with the Adminis-
11 trator to provide the Administrator with such information as
12 may be required to carry out this section:

13 “(1) A PDP sponsor offering a prescription drug plan
14 under this part.

15 “(2) An entity that offers a MA-EFFS Rx plan.

16 “(3) The sponsor of a qualified retiree prescription
17 drug plan (as defined in subsection (f)).

18 “(c) REINSURANCE PAYMENT AMOUNT.—

19 “(1) IN GENERAL.—Subject to subsection (d)(1)(B)
20 and paragraph (4), the reinsurance payment amount under
21 this subsection for a qualifying covered individual (as de-
22 fined in subsection (h)(1)) for a coverage year (as defined
23 in subsection (h)(2)) is equal to the sum of the following:

24 “(A) REINSURANCE BELOW INITIAL COVERAGE
25 LIMIT.—For the portion of the individual’s gross cov-
26 ered prescription drug costs (as defined in paragraph
27 (3)) for the year that exceeds the initial reinsurance
28 threshold specified in paragraph (4), but does not ex-
29 ceed the initial coverage limit specified in section
30 1860D–2(b)(3), an amount equal to 20 percent of the
31 allowable costs (as defined in paragraph (2)) attrib-
32 utable to such gross covered prescription drug costs.

33 “(B) REINSURANCE ABOVE ANNUAL OUT-OF-
34 POCKET THRESHOLD.—For the portion of the individ-
35 ual’s gross covered prescription drug costs for the year
36 that exceeds the annual out-of-pocket threshold speci-
37 fied in 1860D–2(b)(4)(B), an amount equal to 80 per-

1 cent of the allowable costs attributable to such gross
2 covered prescription drug costs.

3 “(2) ALLOWABLE COSTS.—For purposes of this sec-
4 tion, the term ‘allowable costs’ means, with respect to gross
5 covered prescription drug costs under a plan described in
6 subsection (b) offered by a qualifying entity, the part of
7 such costs that are actually paid (net of average percentage
8 rebates) under the plan, but in no case more than the part
9 of such costs that would have been paid under the plan if
10 the prescription drug coverage under the plan were stand-
11 ard coverage.

12 “(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—
13 For purposes of this section, the term ‘gross covered pre-
14 scription drug costs’ means, with respect to an enrollee
15 with a qualifying entity under a plan described in sub-
16 section (b) during a coverage year, the costs incurred under
17 the plan (including costs attributable to administrative
18 costs) for covered prescription drugs dispensed during the
19 year, including costs relating to the deductible, whether
20 paid by the enrollee or under the plan, regardless of wheth-
21 er the coverage under the plan exceeds standard coverage
22 and regardless of when the payment for such drugs is
23 made.

24 “(4) INITIAL REINSURANCE THRESHOLD.—The initial
25 reinsurance threshold specified in this paragraph—

26 “(A) for 2006, is equal to \$1,000; or

27 “(B) for a subsequent year, is equal to the pay-
28 ment threshold specified in this paragraph for the pre-
29 vious year, increased by the annual percentage increase
30 described in section 1860D–2(b)(5) for the year in-
31 volved.

32 Any amount determined under subparagraph (B) that is
33 not a multiple of \$10 shall be rounded to the nearest mul-
34 tiple of \$10.

35 “(d) ADJUSTMENT OF PAYMENTS.—

1 “(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO
2 ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REIN-
3 SURANCE.—

4 “(A) ESTIMATION OF PAYMENTS.—The Adminis-
5 trator shall estimate—

6 “(i) the total payments to be made (without
7 regard to this subsection) during a year under sub-
8 sections (a)(2) and (c); and

9 “(ii) the total payments to be made by quali-
10 fying entities for standard coverage under plans de-
11 scribed in subsection (b) during the year.

12 “(B) ADJUSTMENT.—The Administrator shall pro-
13 portionally adjust the payments made under sub-
14 sections (a)(2) and (c) for a coverage year in such
15 manner so that the total of the payments made under
16 such subsections (and under subsection (f)(3) insofar
17 as such payments reflect payments that would have
18 been made under such subsections if such subsections
19 had applied to qualified retiree prescription drug plans
20 instead of subsections (a)(3) and (f)(3)) for the year is
21 equal to 30 percent of the total payments described in
22 subparagraph (A)(ii).

23 “(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To
24 the extent the Administrator determines it appropriate to
25 avoid risk selection, the payments made for direct subsidies
26 under subsection (a)(1) are subject to adjustment based
27 upon risk factors specified by the Administrator. Any such
28 risk adjustment shall be designed in a manner as to not re-
29 sult in a change in the aggregate payments made under
30 such subsection.

31 “(e) PAYMENT METHODS.—

32 “(1) IN GENERAL.—Payments under this section shall
33 be based on such a method as the Administrator deter-
34 mines. The Administrator may establish a payment method
35 by which interim payments of amounts under this section
36 are made during a year based on the Administrator’s best

1 estimate of amounts that will be payable after obtaining all
2 of the information.

3 “(2) SOURCE OF PAYMENTS.—Payments under this
4 section shall be made from the Medicare Prescription Drug
5 Trust Fund.

6 “(f) RULES RELATING TO QUALIFIED RETIREE PRE-
7SCRIPTION DRUG PLAN.—

8 “(1) DEFINITION.—For purposes of this section, the
9 term ‘qualified retiree prescription drug plan’ means em-
10 ployment-based retiree health coverage (as defined in para-
11 graph (4)(A)) if, with respect to an individual who is a par-
12 ticipant or beneficiary under such coverage and is eligible
13 to be enrolled in a prescription drug plan or a MA-EFFS
14 Rx plan under this part, the following requirements are
15 met:

16 “(A) ACTUARIAL EQUIVALENCE TO STANDARD
17 COVERAGE.—The Administrator determines (based on
18 an actuarial analysis by the Administrator) that cov-
19 erage provides at least the same actuarial value as
20 standard coverage. Such determination may be made
21 on an annual basis.

22 “(B) AUDITS.—The sponsor (and the plan) shall
23 maintain, and afford the Administrator access to, such
24 records as the Administrator may require for purposes
25 of audits and other oversight activities necessary to en-
26 sure the adequacy of prescription drug coverage and
27 the accuracy of payments made.

28 “(C) PROVISION OF CERTIFICATION OF PRESCRIP-
29TION DRUG COVERAGE.—The sponsor of the plan shall
30 provide for issuance of certifications of the type de-
31 scribed in section 1860D–1(c)(2)(D).

32 “(2) LIMITATION ON BENEFIT ELIGIBILITY.—No pay-
33 ment shall be provided under this section with respect to
34 a participant or beneficiary in a qualified retiree prescrip-
35 tion drug plan unless the individual is—

36 “(A) is covered under the plan; and

1 “(B) is eligible to obtain qualified prescription
2 drug coverage under section 1860D–1 but did not elect
3 such coverage under this part (either through a pre-
4 scription drug plan or through a MA-EFFS Rx plan).

5 “(3) EMPLOYER AND UNION SPECIAL SUBSIDY
6 AMOUNTS.—

7 “(A) IN GENERAL.—For purposes of subsection
8 (a), the special subsidy payment amount under this
9 paragraph for a qualifying covered individual (as de-
10 fined in subsection (h)(1)) for a coverage year (as de-
11 fined in subsection (h)(2)) enrolled in a qualifying enti-
12 ty described in subsection (b)(3) under a qualified re-
13 tiree prescription drug plan is, for the portion of the
14 individual’s gross covered prescription drug costs for
15 the year that exceeds the deductible amount specified
16 in subparagraph (B), an amount equal to, subject to
17 subparagraph (D), 28 percent of the allowable costs at-
18 tributable to such gross covered prescription drug
19 costs, but not to exceed, subject to subparagraph (C),
20 \$5,000 (for plan years that end in 2006) in the case
21 of any such individual for the year.

22 “(B) DEDUCTIBLE APPLICABLE.—Subject to sub-
23 paragraph (C), the deductible under this subparagraph
24 is equal to \$250 for plan years that end in 2006.

25 “(C) INDEXING.—The specified in subparagraph
26 (A) and the amount of the deductible under subpara-
27 graph (B) for a year after 2006 shall be adjusted in
28 the same manner as the annual deductible under sec-
29 tion 1860D–2(b)(1) is annually adjusted under such
30 section.

31 “(D) ADJUSTMENT CONTINGENCY.—The Sec-
32 retary may adjust the percentage specified in subpara-
33 graph (A) with respect to plan years that end in a year
34 in a manner so that the aggregate expenditures in the
35 year under this section are the same as the aggregate
36 expenditures that would have been made under this
37 section (taking into account the effect of any adjust-

1 ment under subsection (d)(1)(B)) if paragraphs (1)
2 and (2) of subsection (a) had applied to qualified pre-
3 scription drug coverage instead of this paragraph and
4 subsection (a)(3).

5 “(4) RELATED DEFINITIONS.—As used in this section:

6 “(A) EMPLOYMENT-BASED RETIREE HEALTH COV-
7 ERAGE.—The term ‘employment-based retiree health
8 coverage’ means health insurance or other coverage of
9 health care costs for individuals eligible to enroll in a
10 prescription drug plan or MA-EFFS Rx plan under
11 this part (or for such individuals and their spouses and
12 dependents) under a group health plan (including such
13 a plan that is established or maintained under or pur-
14 suant to one or more collective bargaining agreements)
15 based on their status as retired participants in such
16 plan.

17 “(B) SPONSOR.—The term ‘sponsor’ means a plan
18 sponsor, as defined in section 3(16)(B) of the Em-
19 ployee Retirement Income Security Act of 1974.

20 “(5) CONSTRUCTION.—Nothing in this subsection
21 shall be construed as—

22 “(A) precluding an individual who is covered
23 under employment-based retiree health coverage from
24 enrolling in a prescription drug plan or in a MA-EFFS
25 plan; or

26 “(B) preventing such employment-based retiree
27 health coverage from providing coverage that is supple-
28 mental to the benefits provided under such a prescrip-
29 tion drug plan or MA-EFFS plan; or

30 “(C) precluding such employment-based retiree
31 health coverage or an employer or other person from
32 paying all or any portion of any premium required for
33 coverage under such a prescription drug plan or MA-
34 EFFS plan on behalf of such an individual.

35 “(g) COMPUTATION OF NATIONAL AVERAGE MONTHLY
36 BID AMOUNT.—

1 “(1) IN GENERAL.—For each year (beginning with
2 2006) the Administrator shall compute a national average
3 monthly bid amount equal to the average of the benchmark
4 bid amounts for each prescription drug plan (as computed
5 under paragraph (2), but excluding plans described in sec-
6 tion 1851(a)(2)(C))) adjusted under paragraph (4) to take
7 into account reinsurance payments.

8 “(2) BENCHMARK BID AMOUNT DEFINED.—For pur-
9 poses of this subsection, the term ‘benchmark bid amount’
10 means, with respect to qualified prescription drug coverage
11 offered under—

12 “(A) a prescription drug plan that—

13 “(i) provides standard coverage (or alternative
14 prescription drug coverage the actuarial value is
15 equivalent to that of standard coverage), the PDP
16 bid; or

17 “(ii) provides alternative prescription drug
18 coverage the actuarial value of which is greater
19 than that of standard coverage, the PDP bid multi-
20 plied by the ratio of (I) the actuarial value of
21 standard coverage, to (II) the actuarial value of the
22 alternative coverage; or

23 “(B) a MA-EFFS Rx plan, the portion of the bid
24 amount that is attributable to statutory drug benefits
25 (described in section 1853(a)(1)(A)(ii)(II)).

26 For purposes of subparagraph (A), the term ‘PDP bid’
27 means, with respect to a prescription drug plan, the bid
28 amount for enrollment under the plan under this part (de-
29 termined without regard to any low-income subsidy under
30 section 1860D–7 or any late enrollment penalty under sec-
31 tion 1860D–1(c)(2)(B)).

32 “(3) WEIGHTED AVERAGE.—

33 “(A) IN GENERAL.—The monthly national average
34 monthly bid amount computed under paragraph (1)
35 shall be a weighted average, with the weight for each
36 plan being equal to the average number of beneficiaries
37 enrolled under such plan in the previous year.

1 “(B) SPECIAL RULE FOR 2006.—For purposes of
2 applying this subsection for 2006, the Administrator
3 shall establish procedures for determining the weighted
4 average under subparagraph (A) for 2005.

5 “(4) ADJUSTMENT TO ADD BACK IN VALUE OF REIN-
6 SURANCE SUBSIDIES.—The adjustment under this para-
7 graph, to take into account reinsurance payments under
8 subsection (c) making of 30 percent of total payments, is
9 such an adjustment as will make the national average
10 monthly bid amount represent represent 100 percent, in-
11 stead of representing 70 percent, of average payments
12 under this part.

13 “(h) GENERAL DEFINITIONS.—For purposes of this sec-
14 tion:

15 “(1) QUALIFYING COVERED INDIVIDUAL.—The term
16 ‘qualifying covered individual’ means an individual who—

17 “(A) is enrolled with a prescription drug plan
18 under this part;

19 “(B) is enrolled with a MA-EFFS Rx plan; or

20 “(C) is eligible to obtain qualified prescription
21 drug coverage under section 1860D–1 but did not elect
22 such coverage under this part (either through a pre-
23 scription drug plan or through a MA-EFFS Rx plan)
24 but is covered under a qualified retiree prescription
25 drug plan.

26 “(2) COVERAGE YEAR.—The term ‘coverage year’
27 means a calendar year in which covered outpatient drugs
28 are dispensed if a claim for payment is made under the
29 plan for such drugs, regardless of when the claim is paid.

30 **“SEC. 1860D–9. MEDICARE PRESCRIPTION DRUG TRUST**
31 **FUND.**

32 “(a) IN GENERAL.—There is created on the books of the
33 Treasury of the United States a trust fund to be known as the
34 ‘Medicare Prescription Drug Trust Fund’ (in this section re-
35 ferred to as the ‘Trust Fund’). The Trust Fund shall consist
36 of such gifts and bequests as may be made as provided in sec-
37 tion 201(i)(1), and such amounts as may be deposited in, or

1 appropriated to, such fund as provided in this part. Except as
2 otherwise provided in this section, the provisions of subsections
3 (b) through (i) of section 1841 shall apply to the Trust Fund
4 in the same manner as they apply to the Federal Supple-
5 mentary Medical Insurance Trust Fund under such section.

6 “(b) PAYMENTS FROM TRUST FUND.—

7 “(1) IN GENERAL.—The Managing Trustee shall pay
8 from time to time from the Trust Fund such amounts as
9 the Administrator certifies are necessary to make—

10 “(A) payments under section 1860D–7 (relating to
11 low-income subsidy payments);

12 “(B) payments under section 1860D–8 (relating
13 to subsidy payments); and

14 “(C) payments with respect to administrative ex-
15 penses under this part in accordance with section
16 201(g).

17 “(2) TRANSFERS TO MEDICAID ACCOUNT FOR IN-
18 CREASED ADMINISTRATIVE COSTS.—The Managing Trustee
19 shall transfer from time to time from the Trust Fund to
20 the Grants to States for Medicaid account amounts the Ad-
21 ministrator certifies are attributable to increases in pay-
22 ment resulting from the application of a higher Federal
23 matching percentage under section 1935(b).

24 “(c) DEPOSITS INTO TRUST FUND.—

25 “(1) LOW-INCOME TRANSFER.—There is hereby trans-
26 ferred to the Trust Fund, from amounts appropriated for
27 Grants to States for Medicaid, amounts equivalent to the
28 aggregate amount of the reductions in payments under sec-
29 tion 1903(a)(1) attributable to the application of section
30 1935(c).

31 “(2) APPROPRIATIONS TO COVER GOVERNMENT CON-
32 TRIBUTIONS.—There are authorized to be appropriated
33 from time to time, out of any moneys in the Treasury not
34 otherwise appropriated, to the Trust Fund, an amount
35 equivalent to the amount of payments made from the Trust
36 Fund under subsection (b), reduced by the amount trans-
37 ferred to the Trust Fund under paragraph (1).

1 “(d) RELATION TO SOLVENCY REQUIREMENTS.—Any pro-
2 vision of law that relates to the solvency of the Trust Fund
3 under this part shall take into account the Trust Fund and
4 amounts receivable by, or payable from, the Trust Fund.

5 **“SEC. 1860D-10. DEFINITIONS; APPLICATION TO MEDI-
6 CARE ADVANTAGE AND EFFS PROGRAMS;
7 TREATMENT OF REFERENCES TO PROVI-
8 SIONS IN PART C.**

9 “(a) DEFINITIONS.—For purposes of this part:

10 “(1) COVERED OUTPATIENT DRUGS.—The term ‘cov-
11 ered outpatient drugs’ is defined in section 1860D-2(f).

12 “(2) INITIAL COVERAGE LIMIT.—The term ‘initial cov-
13 erage limit’ means such limit as established under section
14 1860D-2(b)(3), or, in the case of coverage that is not
15 standard coverage, the comparable limit (if any) established
16 under the coverage.

17 “(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—
18 The term ‘Medicare Prescription Drug Trust Fund’ means
19 the Trust Fund created under section 1860D-9(a).

20 “(4) PDP SPONSOR.—The term ‘PDP sponsor’ means
21 an entity that is certified under this part as meeting the
22 requirements and standards of this part for such a sponsor.

23 “(5) PRESCRIPTION DRUG PLAN.—The term ‘prescrip-
24 tion drug plan’ means health benefits coverage that—

25 “(A) is offered under a policy, contract, or plan by
26 a PDP sponsor pursuant to, and in accordance with, a
27 contract between the Administrator and the sponsor
28 under section 1860D-4(b);

29 “(B) provides qualified prescription drug coverage;
30 and

31 “(C) meets the applicable requirements of the sec-
32 tion 1860D-3 for a prescription drug plan.

33 “(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—
34 The term ‘qualified prescription drug coverage’ is defined
35 in section 1860D-2(a).

36 “(7) STANDARD COVERAGE.—The term ‘standard cov-
37 erage’ is defined in section 1860D-2(b).

1 “(b) OFFER OF QUALIFIED PRESCRIPTION DRUG COV-
2 ERAGE UNDER MEDICARE ADVANTAGE AND EFFS PRO-
3 GRAMS.—

4 “(1) AS PART OF MEDICARE ADVANTAGE PLAN.—
5 Medicare Advantage organizations are required to offer
6 Medicare Advantage plans that include qualified prescrip-
7 tion drug coverage under part C pursuant to section
8 1851(j).

9 “(2) AS PART OF EFFS PLAN.—EFFS organizations
10 are required to offer EFFS plans that include qualified
11 prescription drug coverage under part E pursuant to sec-
12 tion 1860E–1(j).

13 “(c) APPLICATION OF PART C PROVISIONS UNDER THIS
14 PART.—For purposes of applying provisions of part C under
15 this part with respect to a prescription drug plan and a PDP
16 sponsor, unless otherwise provided in this part such provisions
17 shall be applied as if—

18 “(1) any reference to a Medicare Advantage or other
19 plan included a reference to a prescription drug plan;

20 “(2) any reference to a provider-sponsored organiza-
21 tion included a reference to a PDP sponsor;

22 “(3) any reference to a contract under section 1857
23 included a reference to a contract under section 1860D–
24 4(b); and

25 “(4) any reference to part C included a reference to
26 this part.”.

27 (b) ADDITIONAL CONFORMING CHANGES.—

28 (1) CONFORMING REFERENCES TO PREVIOUS PART
29 D.—Any reference in law (in effect before the date of the
30 enactment of this Act) to part D of title XVIII of the So-
31 cial Security Act is deemed a reference to part F of such
32 title (as in effect after such date).

33 (2) CONFORMING AMENDMENT PERMITTING WAIVER
34 OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C.
35 1320a–7b(b)(3)) is amended—

36 (A) by striking “and” at the end of subparagraph
37 (E);

1 (B) by striking the period at the end of subpara-
2 graph (F) and inserting “; and”; and

3 (C) by adding at the end the following new sub-
4 paragraph:

5 “(G) the waiver or reduction of any cost-sharing im-
6 posed under part D of title XVIII.”.

7 (3) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not
8 later than 6 months after the date of the enactment of this
9 Act, the Secretary of Health and Human Services shall
10 submit to the appropriate committees of Congress a legisla-
11 tive proposal providing for such technical and conforming
12 amendments in the law as are required by the provisions
13 of this subtitle.

14 (c) STUDY ON TRANSITIONING PART B PRESCRIPTION
15 DRUG COVERAGE.—Not later than January 1, 2005, the Medi-
16 care Benefits Administrator shall submit a report to Congress
17 that makes recommendations regarding methods for providing
18 benefits under part D of title XVIII of the Social Security Act
19 for outpatient prescription drugs for which benefits are pro-
20 vided under part B of such title.

21 (d) REPORT ON PHARMACY SERVICES PROVIDED TO
22 NURSING FACILITY PATIENTS.—

23 (1) REVIEW.—Within 6 months after the date of the
24 enactment of this Act, the Secretary shall review the cur-
25 rent standards of practice for pharmacy services provided
26 to patients in nursing facilities.

27 (2) EVALUATIONS AND RECOMMENDATIONS.—Specifi-
28 cally in the review under paragraph (1), the Secretary
29 shall—

30 (A) assess the current standards of practice, clin-
31 ical services, and other service requirements generally
32 utilized for pharmacy services in the long-term care set-
33 ting;

34 (B) evaluate the impact of those standards with
35 respect to patient safety, reduction of medication errors
36 and quality of care; and

(C) recommend (in the Secretary's report under paragraph (3)) necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

(3) REPORT.—The Secretary shall submit a report to the Congress on the Secretary's findings and recommendations under this section, including a detailed description of the Secretary's plans to implement the amendments made by this section in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients.

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE AND ENHANCED FEE-FOR-SERVICE (EFFS) PROGRAM.

(a) MEDICARE ADVANTAGE.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

“(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS AND SUBSIDIES.—

“(1) OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—A Medicare Advantage organization on and after January 1, 2006—

“(A) may not offer a Medicare Advantage plan described in section 1851(a)(2)(A) in an area unless either that plan (or another Medicare Advantage plan offered by the organization in that area) includes qualified prescription drug coverage; and

“(B) may not offer the prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare Advantage plan, unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

1 “(2) REQUIREMENT FOR ELECTION OF PART D COV-
2 ERAGE TO OBTAIN QUALIFIED PRESCRIPTION DRUG COV-
3 ERAGE.—For purposes of this part, an individual who has
4 not elected qualified prescription drug coverage under sec-
5 tion 1860D–1(b) shall be treated as being ineligible to en-
6 roll in a Medicare Advantage plan under this part that of-
7 fers such coverage.

8 “(3) COMPLIANCE WITH CERTAIN ADDITIONAL BENE-
9 FICIARY PROTECTIONS FOR PRESCRIPTION DRUG COV-
10 ERAGE.—With respect to the offering of qualified prescrip-
11 tion drug coverage by a Medicare Advantage organization
12 under this part on and after January 1, 2006, the organi-
13 zation and plan shall meet the requirements of subsections
14 (a) through (d) of section 1860D–3 in the same manner as
15 they apply to a PDP sponsor and a prescription drug plan
16 under part D and shall submit to the Administrator the in-
17 formation described in section 1860D–6(a)(2). The Admin-
18 istrator shall waive such requirements to the extent the Ad-
19 ministrator determines that such requirements duplicate re-
20 quirements otherwise applicable to the organization or plan
21 under this part.

22 “(4) AVAILABILITY OF PREMIUM AND COST-SHARING
23 SUBSIDIES.—In the case of low-income individuals who are
24 enrolled in a Medicare Advantage plan that provides quali-
25 fied prescription drug coverage, premium and cost-sharing
26 subsidies are provided for such coverage under section
27 1860D–7.

28 “(5) AVAILABILITY OF DIRECT AND REINSURANCE
29 SUBSIDIES TO REDUCE BIDS AND PREMIUMS.—Medicare
30 Advantage organizations are provided direct and insurance
31 subsidy payments for providing qualified prescription drug
32 coverage under this part under section 1860D–8.

33 “(6) CONSOLIDATION OF DRUG AND NON-DRUG PRE-
34 MIUMS.—In the case of a Medicare Advantage plan that in-
35 cludes qualified prescription drug coverage, with respect to
36 an enrollee in such plan there shall be a single premium

1 for both drug and non-drug coverage provided under the
2 plan.

3 “(7) TRANSITION IN INITIAL ENROLLMENT PERIOD.—
4 Notwithstanding any other provision of this part, the an-
5 nual, coordinated election period under subsection (e)(3)(B)
6 for 2006 shall be the 6-month period beginning with No-
7 vember 2005.

8 “(8) QUALIFIED PRESCRIPTION DRUG COVERAGE;
9 STANDARD COVERAGE.—For purposes of this part, the
10 terms ‘qualified prescription drug coverage’ and ‘standard
11 coverage’ have the meanings given such terms in section
12 1860D–2.”.

13 (b) APPLICATION TO EFFS PLANS.—Subsection (d) of
14 section 1860E–2, as added by section 201(a), is amended to
15 read as follows:

16 “(d) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS
17 AND SUBSIDIES.—

18 “(1) OFFERING OF QUALIFIED PRESCRIPTION DRUG
19 COVERAGE.—An EFFS organization—

20 “(A) may not offer an EFFS plan in an area un-
21 less either that plan (or another EFFS plan offered by
22 the organization in that area) includes qualified pre-
23 scription drug coverage; and

24 “(B) may not offer the prescription drug coverage
25 (other than that required under parts A and B) to an
26 enrollee under an EFFS plan, unless such drug cov-
27 erage is at least qualified prescription drug coverage
28 and unless the requirements of this subsection with re-
29 spect to such coverage are met.

30 “(2) REQUIREMENT FOR ELECTION OF PART D COV-
31 ERAGE TO OBTAIN QUALIFIED PRESCRIPTION DRUG COV-
32 ERAGE.—For purposes of this part, an individual who has
33 not elected qualified prescription drug coverage under sec-
34 tion 1860D–1(b) shall be treated as being ineligible to en-
35 roll in an EFFS plan under this part that offers such cov-
36 erage.

1 “(3) COMPLIANCE WITH CERTAIN ADDITIONAL BENE-
2 FICIARY PROTECTIONS FOR PRESCRIPTION DRUG COV-
3 ERAGE.—With respect to the offering of qualified prescrip-
4 tion drug coverage by an EFFS organization under this
5 part, the organization and plan shall meet the requirements
6 of subsections (a) through (d) of section 1860D–3 in the
7 same manner as they apply to a PDP sponsor and a pre-
8 scription drug plan under part D and shall submit to the
9 Administrator the information described in section 1860D–
10 6(a)(2). The Administrator shall waive such requirements
11 to the extent the Administrator determines that such re-
12 quirements duplicate requirements otherwise applicable to
13 the organization or plan under this part.

14 “(4) AVAILABILITY OF PREMIUM AND COST-SHARING
15 SUBSIDIES.—In the case of low-income individuals who are
16 enrolled in an EFFS plan that provides qualified prescrip-
17 tion drug coverage, premium and cost-sharing subsidies are
18 provided for such coverage under section 1860D–7.

19 “(5) AVAILABILITY OF DIRECT AND REINSURANCE
20 SUBSIDIES TO REDUCE BIDS AND PREMIUMS.—EFFS orga-
21 nizations are provided direct and insurance subsidy pay-
22 ments for providing qualified prescription drug coverage
23 under this part under section 1860D–8.

24 “(6) CONSOLIDATION OF DRUG AND NON-DRUG PRE-
25 MIUMS.—In the case of an EFFS plan that includes quali-
26 fied prescription drug coverage, with respect to an enrollee
27 in such plan there shall be a single premium for both drug
28 and non-drug coverage provided under the plan.

29 “(7) QUALIFIED PRESCRIPTION DRUG COVERAGE;
30 STANDARD COVERAGE.—For purposes of this part, the
31 terms ‘qualified prescription drug coverage’ and ‘standard
32 coverage’ have the meanings given such terms in section
33 1860D–2.”.

34 (c) CONFORMING AMENDMENTS.—Section 1851 (42
35 U.S.C. 1395w–21) is amended—

36 (1) in subsection (a)(1)—

1 (A) by inserting “(other than qualified prescrip-
2 tion drug benefits)” after “benefits”;

3 (B) by striking the period at the end of subpara-
4 graph (B) and inserting a comma; and

5 (C) by adding after and below subparagraph (B)
6 the following:

7 “and may elect qualified prescription drug coverage in ac-
8 cordance with section 1860D–1.”; and

9 (2) in subsection (g)(1), by inserting “and section
10 1860D–1(c)(2)(B)” after “in this subsection”.

11 (d) EFFECTIVE DATE.—The amendments made by this
12 section apply to coverage provided on or after January 1, 2006.

13 **SEC. 103. MEDICAID AMENDMENTS.**

14 (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME
15 SUBSIDIES.—

16 (1) REQUIREMENT.—Section 1902(a) (42 U.S.C.
17 1396a(a)) is amended—

18 (A) by striking “and” at the end of paragraph
19 (64);

20 (B) by striking the period at the end of paragraph
21 (65) and inserting “; and”; and

22 (C) by inserting after paragraph (65) the following
23 new paragraph:

24 “(66) provide for making eligibility determinations
25 under section 1935(a).”.

26 (2) NEW SECTION.—Title XIX is further amended—

27 (A) by redesignating section 1935 as section 1936;
28 and

29 (B) by inserting after section 1934 the following
30 new section:

31 “SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION
32 DRUG BENEFIT

33 “SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY
34 DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condi-
35 tion of its State plan under this title under section 1902(a)(66)
36 and receipt of any Federal financial assistance under section
37 1903(a), a State shall—

1 “(1) make determinations of eligibility for premium
2 and cost-sharing subsidies under (and in accordance with)
3 section 1860D–7;

4 “(2) inform the Administrator of the Medicare Bene-
5 fits Administration of such determinations in cases in
6 which such eligibility is established; and

7 “(3) otherwise provide such Administrator with such
8 information as may be required to carry out part D of title
9 XVIII (including section 1860D–7).

10 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE
11 COSTS.—

12 “(1) IN GENERAL.—The amounts expended by a State
13 in carrying out subsection (a) are, subject to paragraph
14 (2), expenditures reimbursable under the appropriate para-
15 graph of section 1903(a); except that, notwithstanding any
16 other provision of such section, the applicable Federal
17 matching rates with respect to such expenditures under
18 such section shall be increased as follows (but in no case
19 shall the rate as so increased exceed 100 percent):

20 “(A) For expenditures attributable to costs in-
21 curred during 2005, the otherwise applicable Federal
22 matching rate shall be increased by 10 percent of the
23 percentage otherwise payable (but for this subsection)
24 by the State.

25 “(B)(i) For expenditures attributable to costs in-
26 curred during 2006 and each subsequent year through
27 2013, the otherwise applicable Federal matching rate
28 shall be increased by the applicable percent (as defined
29 in clause (ii)) of the percentage otherwise payable (but
30 for this subsection) by the State.

31 “(ii) For purposes of clause (i), the ‘applicable
32 percent’ for—

33 “(I) 2006 is 20 percent; or

34 “(II) a subsequent year is the applicable per-
35 cent under this clause for the previous year in-
36 creased by 10 percentage points.

1 “(C) For expenditures attributable to costs in-
2 curred after 2013, the otherwise applicable Federal
3 matching rate shall be increased to 100 percent.

4 “(2) COORDINATION.—The State shall provide the Ad-
5 ministrators with such information as may be necessary to
6 properly allocate administrative expenditures described in
7 paragraph (1) that may otherwise be made for similar eligi-
8 bility determinations.”.

9 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RE-
10 SPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES
11 FOR DUALY ELIGIBLE INDIVIDUALS.—

12 (1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C.
13 1396b(a)(1)) is amended by inserting before the semicolon
14 the following: “, reduced by the amount computed under
15 section 1935(c)(1) for the State and the quarter”.

16 (2) AMOUNT DESCRIBED.—Section 1935, as inserted
17 by subsection (a)(2), is amended by adding at the end the
18 following new subsection:

19 “(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION
20 DRUG COSTS FOR DUALY-ELIGIBLE BENEFICIARIES.—

21 “(1) IN GENERAL.—For purposes of section
22 1903(a)(1), for a State that is one of the 50 States or the
23 District of Columbia for a calendar quarter in a year (be-
24 ginning with 2005) the amount computed under this sub-
25 section is equal to the product of the following:

26 “(A) MEDICARE SUBSIDIES.—The total amount of
27 payments made in the quarter under section 1860D–7
28 (relating to premium and cost-sharing prescription
29 drug subsidies for low-income medicare beneficiaries)
30 that are attributable to individuals who are residents of
31 the State and are entitled to benefits with respect to
32 prescribed drugs under the State plan under this title
33 (including such a plan operating under a waiver under
34 section 1115).

35 “(B) STATE MATCHING RATE.—A proportion com-
36 puted by subtracting from 100 percent the Federal

1 medical assistance percentage (as defined in section
2 1905(b)) applicable to the State and the quarter.

3 “(C) PHASE-OUT PROPORTION.—The phase-out
4 proportion (as defined in paragraph (2)) for the quar-
5 ter.

6 “(2) PHASE-OUT PROPORTION.—For purposes of para-
7 graph (1)(C), the ‘phase-out proportion’ for a calendar
8 quarter in—

9 “(A) 2006 is 93-1/3 percent;

10 “(B) a subsequent year before 2021, is the phase-
11 out proportion for calendar quarters in the previous
12 year decreased by 6-2/3 percentage points; or

13 “(C) a year after 2020 is 0 percent.”.

14 (c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—
15 Section 1935, as so inserted and amended, is further amended
16 by adding at the end the following new subsection:

17 “(d) ADDITIONAL PROVISIONS.—

18 “(1) MEDICAID AS SECONDARY PAYOR.—In the case of
19 an individual who is entitled to qualified prescription drug
20 coverage under a prescription drug plan under part D of
21 title XVIII (or under a MA-EFFS Rx plan under part C
22 or E of such title) and medical assistance for prescribed
23 drugs under this title, medical assistance shall continue to
24 be provided under this title (other than for copayment
25 amounts specified in section 1860D-7(a)(1)(B), notwith-
26 standing section 1916) for prescribed drugs to the extent
27 payment is not made under the prescription drug plan or
28 MA-EFFS Rx plan selected by the individual.

29 “(2) CONDITION.—A State may require, as a condition
30 for the receipt of medical assistance under this title with
31 respect to prescription drug benefits for an individual eligi-
32 ble to obtain qualified prescription drug coverage described
33 in paragraph (1), that the individual elect qualified pre-
34 scription drug coverage under section 1860D-1.”.

35 (d) TREATMENT OF TERRITORIES.—

36 (1) IN GENERAL.—Section 1935, as so inserted and
37 amended, is further amended—

1 (A) in subsection (a) in the matter preceding para-
2 graph (1), by inserting “subject to subsection (e)” after
3 “section 1903(a)”;

4 (B) in subsection (c)(1), by inserting “subject to
5 subsection (e)” after “1903(a)(1)”; and

6 (C) by adding at the end the following new sub-
7 section:

8 “(e) TREATMENT OF TERRITORIES.—

9 “(1) IN GENERAL.—In the case of a State, other than
10 the 50 States and the District of Columbia—

11 “(A) the previous provisions of this section shall
12 not apply to residents of such State; and

13 “(B) if the State establishes a plan described in
14 paragraph (2) (for providing medical assistance with
15 respect to the provision of prescription drugs to medi-
16 care beneficiaries), the amount otherwise determined
17 under section 1108(f) (as increased under section
18 1108(g)) for the State shall be increased by the
19 amount specified in paragraph (3).

20 “(2) PLAN.—The plan described in this paragraph is
21 a plan that—

22 “(A) provides medical assistance with respect to
23 the provision of covered outpatient drugs (as defined in
24 section 1860D–2(f)) to low-income medicare bene-
25 ficiaries; and

26 “(B) assures that additional amounts received by
27 the State that are attributable to the operation of this
28 subsection are used only for such assistance.

29 “(3) INCREASED AMOUNT.—

30 “(A) IN GENERAL.—The amount specified in this
31 paragraph for a State for a year is equal to the product
32 of—

33 “(i) the aggregate amount specified in sub-
34 paragraph (B); and

35 “(ii) the amount specified in section
36 1108(g)(1) for that State, divided by the sum of

1 the amounts specified in such section for all such
2 States.

3 “(B) AGGREGATE AMOUNT.—The aggregate
4 amount specified in this subparagraph for—

5 “(i) 2006, is equal to \$25,000,000; or

6 “(ii) a subsequent year, is equal to the aggre-
7 gate amount specified in this subparagraph for the
8 previous year increased by annual percentage in-
9 crease specified in section 1860D–2(b)(5) for the
10 year involved.

11 “(4) REPORT.—The Administrator shall submit to
12 Congress a report on the application of this subsection and
13 may include in the report such recommendations as the Ad-
14 ministrator deems appropriate.”.

15 (2) CONFORMING AMENDMENT.—Section 1108(f) (42
16 U.S.C. 1308(f)) is amended by inserting “and section
17 1935(e)(1)(B)” after “Subject to subsection (g)”.

18 (e) AMENDMENT TO BEST PRICE.—Section
19 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

20 (1) by striking “and” at the end of subclause (III);

21 (2) by striking the period at the end of subclause (IV)
22 and inserting “; and”; and

23 (3) by adding at the end the following new subclause:

24 “(V) any prices charged which are nego-
25 tiated by a prescription drug plan under part
26 D of title XVIII, by a MA-EFFS Rx plan
27 under part C or E of such title with respect to
28 covered outpatient drugs, or by a qualified re-
29 tiree prescription drug plan (as defined in sec-
30 tion 1860D–8(f)(1)) with respect to such drugs
31 on behalf of individuals entitled to benefits
32 under part A or enrolled under part B of such
33 title.”.

34 **SEC. 104. MEDIGAP TRANSITION.**

35 (a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is
36 amended by adding at the end the following new subsection:

37 “(v) COVERAGE OF PRESCRIPTION DRUGS.—

1 “(1) IN GENERAL.—Notwithstanding any other provi-
2 sion of law, except as provided in paragraph (3) no new
3 medicare supplemental policy that provides coverage of ex-
4 penses for prescription drugs may be issued under this sec-
5 tion on or after January 1, 2006, to an individual unless
6 it replaces a medicare supplemental policy that was issued
7 to that individual and that provided some coverage of ex-
8 penses for prescription drugs.

9 “(2) ISSUANCE OF SUBSTITUTE POLICIES FOR BENE-
10 FICIARIES ENROLLED WITH A PLAN UNDER PART D.—

11 “(A) IN GENERAL.—The issuer of a medicare sup-
12 plemental policy—

13 “(i) may not deny or condition the issuance or
14 effectiveness of a medicare supplemental policy that
15 has a benefit package classified as ‘A’, ‘B’, ‘C’, ‘D’,
16 ‘E’, ‘F’, or ‘G’ (under the standards established
17 under subsection (p)(2)) and that is offered and is
18 available for issuance to new enrollees by such
19 issuer;

20 “(ii) may not discriminate in the pricing of
21 such policy, because of health status, claims experi-
22 ence, receipt of health care, or medical condition;
23 and

24 “(iii) may not impose an exclusion of benefits
25 based on a pre-existing condition under such policy,
26 in the case of an individual described in subparagraph
27 (B) who seeks to enroll under the policy not later than
28 63 days after the date of the termination of enrollment
29 described in such paragraph and who submits evidence
30 of the date of termination or disenrollment along with
31 the application for such medicare supplemental policy.

32 “(B) INDIVIDUAL COVERED.—An individual de-
33 scribed in this subparagraph is an individual who—

34 “(i) enrolls in a prescription drug plan under
35 part D; and

36 “(ii) at the time of such enrollment was en-
37 rolled and terminates enrollment in a medicare sup-

1 plemental policy which has a benefit package classi-
2 fied as ‘H’, ‘I’, or ‘J’ under the standards referred
3 to in subparagraph (A)(i) or terminates enrollment
4 in a policy to which such standards do not apply
5 but which provides benefits for prescription drugs.

6 “(C) ENFORCEMENT.—The provisions of para-
7 graph (4) of subsection (s) shall apply with respect to
8 the requirements of this paragraph in the same manner
9 as they apply to the requirements of such subsection.

10 “(3) NEW STANDARDS.—In applying subsection
11 (p)(1)(E) (including permitting the NAIC to revise its
12 model regulations in response to changes in law) with re-
13 spect to the change in benefits resulting from title I of the
14 Medicare Prescription Drug and Modernization Act of
15 2003, with respect to policies issued to individuals who are
16 enrolled in a plan under part D, the changes in standards
17 shall only provide for substituting (for the benefit packages
18 described in paragraph (2)(B)(ii) that included coverage for
19 prescription drugs) two benefit packages that may provide
20 for coverage of cost-sharing (other than the prescription
21 drug deductible) with respect to qualified prescription drug
22 coverage under such part. The two benefit packages shall
23 be consistent with the following:

24 “(A) FIRST NEW POLICY.—The policy described in
25 this subparagraph has the following benefits, notwith-
26 standing any other provision of this section relating to
27 a core benefit package:

28 “(i) Coverage of 50 percent of the cost-sharing
29 otherwise applicable, except coverage of 100 per-
30 cent of any cost-sharing otherwise applicable for
31 preventive benefits.

32 “(ii) No coverage of the part B deductible.

33 “(iii) Coverage for all hospital coinsurance for
34 long stays (as in the current core benefit package).

35 “(iv) A limitation on annual out-of-pocket ex-
36 penditures to \$4,000 in 2005 (or, in a subsequent
37 year, to such limitation for the previous year in-

1 creased by an appropriate inflation adjustment
2 specified by the Secretary).

3 “(B) SECOND NEW POLICY.—The policy described
4 in this subparagraph has the same benefits as the pol-
5 icy described in subparagraph (A), except as follows:

6 “(i) Substitute ‘75 percent’ for ‘50 percent’ in
7 clause (i) of such subparagraph.

8 “(ii) Substitute ‘\$2,000’ for ‘\$4,000’ in clause
9 (iv) of such subparagraph.

10 “(4) CONSTRUCTION.—Any provision in this section or
11 in a medicare supplemental policy relating to guaranteed
12 renewability of coverage shall be deemed to have been met
13 through the offering of other coverage under this sub-
14 section.”.

15 (b) NAIC REPORT TO CONGRESS ON MEDIGAP MOD-
16 ERNIZATION.—The Secretary shall request the National Asso-
17 ciation of Insurance Commissioners to submit to Congress, not
18 later than 18 months after the date of the enactment of this
19 Act, a report that includes recommendations on the moderniza-
20 tion of coverage under the medigap program under section
21 1882 of the Social Security Act (42 U.S.C. 1395ss).

22 **SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT**
23 **CARD ENDORSEMENT PROGRAM.**

24 (a) IN GENERAL.—Title XVIII is amended by inserting
25 after section 1806 the following new section:

26 “MEDICARE PRESCRIPTION DRUG DISCOUNT CARD
27 ENDORSEMENT PROGRAM

28 “SEC. 1807. (a) ESTABLISHMENT OF PROGRAM.—

29 “(1) IN GENERAL.—The Secretary (or the Medicare
30 Benefits Administrator pursuant to section 1809(c)(3)(C))
31 shall establish a program to endorse prescription drug dis-
32 count card programs (each such program referred to as an
33 ‘endorsed program’) that meet the requirements of this sec-
34 tion in order to provide access to prescription drug dis-
35 counts for medicare beneficiaries throughout the United
36 States. The Secretary shall make available to medicare

1 beneficiaries information regarding endorsed programs
2 under this section.

3 “(2) LIMITED PERIOD OF OPERATION.—The Secretary
4 shall begin the program under this section as soon as pos-
5 sible, but in no case later than 90 days after the date of
6 the enactment of this section. The Secretary shall provide
7 for an appropriate transition and discontinuation of such
8 program at the time medicare prescription drug benefits
9 first become available under part D.

10 “(b) REQUIREMENTS FOR CARD ENDORSEMENT COMPO-
11 NENT.—The Secretary may not endorse a prescription drug
12 discount card program under this section unless the program
13 meets the following requirements:

14 “(1) SAVINGS TO MEDICARE BENEFICIARIES.—The
15 program passes on to medicare beneficiaries who enroll in
16 the program discounts, rebates, and other price concessions
17 on prescription drugs, including discounts negotiated with
18 pharmacies and manufacturers.

19 “(2) PROHIBITION ON APPLICATION ONLY TO MAIL
20 ORDER.—The program applies to drugs that are available
21 other than solely through mail order.

22 “(3) BENEFICIARY SERVICES.—The program provides
23 pharmaceutical support services, such as education and
24 counseling, and services to prevent adverse drug inter-
25 actions.

26 “(4) INFORMATION.—The program makes available to
27 medicare beneficiaries through the Internet and otherwise
28 information, including information on enrollment fees,
29 prices charged to beneficiaries, and services offered under
30 the program, that the Secretary identifies as being nec-
31 essary to provide for informed choice by beneficiaries
32 among endorsed programs.

33 “(5) DEMONSTRATED EXPERIENCE.—The program is
34 operated directly, or through arrangements with affiliated
35 organization, by an entity that has demonstrated experience
36 and expertise in operating such a program or a similar pro-
37 gram.

1 “(6) QUALITY ASSURANCE.—Such operating entity has
2 in place adequate procedures for assuring quality service
3 under the program.

4 “(7) ENROLLMENT FEES.—The program may charge
5 an annual enrollment fee, but the amount of such annual
6 fee may not exceed \$30. A State may pay some or all of
7 the fee for individuals residing in the State.

8 “(8) CONFIDENTIALITY PROTECTIONS.—The program
9 implements policies and procedures to safeguard the use
10 and disclosure of program beneficiaries’ individually identi-
11 fiable health information in a manner consistent with the
12 Federal regulations (concerning the privacy of individually
13 identifiable health information) promulgated under section
14 264(c) of the Health Insurance Portability and Account-
15 ability Act of 1996.

16 “(9) PERIODIC REPORTS TO SECRETARY.—The entity
17 operating the program shall submit to the Secretary peri-
18 odic reports on performance, utilization, finances, and such
19 other matters as the Secretary may specify.

20 “(10) ADDITIONAL BENEFICIARY PROTECTIONS.—The
21 program meets such additional requirements as the Sec-
22 retary identifies to protect and promote the interest of
23 medicare beneficiaries, including requirements that ensure
24 that beneficiaries are not charged more than the lower of
25 the negotiated retail price or the usual and customary
26 price.

27 The prices negotiated by a prescription drug discount card pro-
28 gram endorsed under this section shall (notwithstanding any
29 other provision of law) not be taken into account for the pur-
30 poses of establishing the best price under section
31 1927(c)(1)(C).

32 “(c) PROGRAM OPERATION.—The Secretary shall operate
33 the program under this section consistent with the following:

34 “(1) PROMOTION OF INFORMED CHOICE.—In order to
35 promote informed choice among endorsed prescription drug
36 discount card programs, the Secretary shall provide for the
37 dissemination of information which compares the prices

1 and services of such programs in a manner coordinated
2 with the dissemination of educational information on Medi-
3 care Advantage plans under part C.

4 “(2) OVERSIGHT.—The Secretary shall provide appro-
5 priate oversight to ensure compliance of endorsed programs
6 with the requirements of this section, including verification
7 and disclosure (upon request) of the discounts and services
8 provided, the amount of dispensing fees recognized, and au-
9 dits under section 1860D–2(d)(3).

10 “(3) USE OF MEDICARE TOLL-FREE NUMBER.—The
11 Secretary shall provide through the 1-800-medicare toll free
12 telephone number for the receipt and response to inquiries
13 and complaints concerning the program and programs en-
14 dored under this section.

15 “(4) SANCTIONS FOR ABUSIVE PRACTICES.—The Sec-
16 retary may implement intermediate sanctions or may re-
17 voke the endorsement of a program in the case of a pro-
18 gram that the Secretary determines no longer meets the re-
19 quirements of this section or that has engaged in false or
20 misleading marketing practices.

21 “(5) ENROLLMENT PRACTICES.—A medicare bene-
22 ficiary may not be enrolled in more than one endorsed pro-
23 gram at any time. A medicare beneficiary may change the
24 endorsed program in which the beneficiary is enrolled, but
25 may not make such change until the beneficiary has been
26 enrolled in a program for a minimum period of time speci-
27 fied by the Secretary.

28 “(d) AUTHORIZATION OF APPROPRIATIONS.—There are
29 authorized to be appropriated such sums as may be necessary
30 to carry out this section.

31 “(e) INTERIM, FINAL REGULATORY AUTHORITY.—In
32 order to carry out this section in a timely manner, the Sec-
33 retary may promulgate regulations that take effect on an in-
34 terim basis, after notice and pending opportunity for public
35 comment.”.

36 (b) CONFORMING AMENDMENT.—Section
37 1927(c)(1)(C)(i)(V) (42 U.S.C. 1396r–8(c)(1)(C)(i)(V)), as

1 added by section 103(e), is amended by striking “or by a quali-
2 fied retiree prescription drug plan (as defined in section
3 1860D–8(f)(1))” and inserting “by a qualified retiree prescrip-
4 tion drug plan (as defined in section 1860D–8(f)(1)), or by a
5 prescription drug discount card program endorsed under sec-
6 tion 1807”.

7 **SEC. 106. DISCLOSURE OF RETURN INFORMATION FOR**
8 **PURPOSES OF CARRYING OUT MEDICARE**
9 **CATASTROPHIC PRESCRIPTION DRUG PRO-**
10 **GRAM.**

11 (a) IN GENERAL.—Subsection (l) of section 6103 of the
12 Internal Revenue Code of 1986 (relating to disclosure of re-
13 turns and return information for purposes other than tax ad-
14 ministration) is amended by adding at the end the following
15 new paragraph:

16 “(19) DISCLOSURE OF RETURN INFORMATION FOR
17 PURPOSES OF CARRYING OUT MEDICARE CATASTROPHIC
18 PRESCRIPTION DRUG PROGRAM.—

19 “(A) IN GENERAL.—The Secretary may, upon
20 written request from the Secretary of Health and
21 Human Services under section 1860D–2(b)(4)(E)(i) of
22 the Social Security Act, disclose to officers and employ-
23 ees of the Department of Health and Human Services
24 with respect to a specified taxpayer for the taxable year
25 specified by the Secretary of Health and Human Serv-
26 ices in such request—

27 “(i) the taxpayer identity information with re-
28 spect to such taxpayer, and

29 “(ii) the adjusted gross income of such tax-
30 payer for the taxable year (or, if less, the income
31 threshold limit specified in section 1860D–
32 2(b)(4)(D)(ii) for the calendar year specified by
33 such Secretary in such request).

34 “(B) SPECIFIED TAXPAYER.—For purposes of this
35 paragraph, the term ‘specified taxpayer’ means any
36 taxpayer who—

1 “(i) is identified by the Secretary of Health
2 and Human Services in the request referred to in
3 subparagraph (A), and

4 “(ii) either—

5 “(I) has an adjusted gross income for the
6 taxable year referred to in subparagraph (A) in
7 excess of the income threshold specified in sec-
8 tion 1860D–2(b)(4)(D)(ii) of such Act for the
9 calendar year referred to in such subparagraph,
10 or

11 “(II) is identified by such Secretary under
12 subparagraph (A) as being an individual who
13 elected to use more recent information under
14 section 1860D–2(b)(4)(D)(v) of such Act.

15 “(C) JOINT RETURNS.—In the case of a joint re-
16 turn, the Secretary shall, for purposes of applying this
17 paragraph, treat each spouse as a separate taxpayer
18 having an adjusted gross income equal to one-half of
19 the adjusted gross income determined with respect to
20 such return.

21 “(D) RESTRICTION ON USE OF DISCLOSED INFOR-
22 MATION.—Return information disclosed under subpara-
23 graph (A) may be used by officers and employees of the
24 Department of Health and Human Services only for
25 the purpose of administering the prescription drug ben-
26 efit under title XVIII of the Social Security Act. Such
27 officers and employees may disclose the annual out-of-
28 pocket threshold which applies to an individual under
29 such part to the entity that offers the plan referred to
30 in section 1860D–2(b)(4)(E)(ii) of such Act in which
31 such individual is enrolled. Such sponsor may use such
32 information only for purposes of administering such
33 benefit.”.

34 (b) CONFIDENTIALITY.—Paragraph (3) of section 6103(a)
35 of such Code is amended by striking “or (16)” and inserting
36 “(16), or (19)”.

1 (c) PROCEDURES AND RECORDKEEPING RELATED TO DIS-
2 CLOSURES.—Subsection (p)(4) of section 6103 of such Code is
3 amended by striking “any other person described in subsection
4 (l)(16) or (17)” each place it appears and inserting “any other
5 person described in subsection (l)(16), (17), or (19)”.

6 (d) UNAUTHORIZED DISCLOSURE.—Paragraph (2) of sec-
7 tion 7213(a) of such Code is amended by striking “or (16)”
8 and inserting “(16), or (19)”.

9 (e) UNAUTHORIZED INSPECTION.—Subparagraph (B) of
10 section 7213A(a)(1) of such Code is amended by inserting “or
11 (19)” after “subsection (l)(18)”.

12 **SEC. 107. STATE PHARMACEUTICAL ASSISTANCE TRAN-**
13 **SITION COMMISSION.**

14 (a) ESTABLISHMENT.—

15 (1) IN GENERAL.—There is established, as of the first
16 day of the third month beginning after the date of the en-
17 actment of this Act, a State Pharmaceutical Assistance
18 Transition Commission (in this section referred to as the
19 “Commission”) to develop a proposal for addressing the
20 unique transitional issues facing State pharmaceutical as-
21 sistance programs, and program participants, due to the
22 implementation of the medicare prescription drug program
23 under part D of title XVIII of the Social Security Act.

24 (2) DEFINITIONS.—For purposes of this section:

25 (A) STATE PHARMACEUTICAL ASSISTANCE PRO-
26 GRAM DEFINED.—The term “State pharmaceutical as-
27 sistance program” means a program (other than the
28 medicaid program) operated by a State (or under con-
29 tract with a State) that provides as of the date of the
30 enactment of this Act assistance to low-income medi-
31 care beneficiaries for the purchase of prescription
32 drugs.

33 (B) PROGRAM PARTICIPANT.—The term “program
34 participant” means a low-income medicare beneficiary
35 who is a participant in a State pharmaceutical assist-
36 ance program.

1 (b) COMPOSITION.—The Commission shall include the fol-
2 lowing:

3 (1) A representative of each governor of each State
4 that the Secretary identifies as operating on a statewide
5 basis a State pharmaceutical assistance program that pro-
6 vides for eligibility and benefits that are comparable or
7 more generous than the low-income assistance eligibility
8 and benefits offered under part D of title XVIII of the So-
9 cial Security Act.

10 (2) Representatives from other States that the Sec-
11 retary identifies have in operation other State pharma-
12 ceutical assistance programs, as appointed by the Sec-
13 retary.

14 (3) Representatives of organizations that have an in-
15 herent interest in program participants or the program
16 itself, as appointed by the Secretary but not to exceed the
17 number of representatives under paragraphs (1) and (2).

18 (4) Representatives of Medicare Advantage organiza-
19 tions and other private health insurance plans, as ap-
20 pointed by the Secretary.

21 (5) The Secretary (or the Secretary's designee) and
22 such other members as the Secretary may specify

23 The Secretary shall designate a member to serve as chair of
24 the Commission and the Commission shall meet at the call of
25 the chair.

26 (c) DEVELOPMENT OF PROPOSAL.—The Commission shall
27 develop the proposal described in subsection (a) in a manner
28 consistent with the following principles:

29 (1) Protection of the interests of program participants
30 in a manner that is the least disruptive to such participants
31 and that includes a single point of contact for enrollment
32 and processing of benefits.

33 (2) Protection of the financial and flexibility interests
34 of States so that States are not financially worse off as a
35 result of the enactment of this title.

36 (3) Principles of medicare modernization provided
37 under title II of this Act.

1 (d) REPORT.—By not later than January 1, 2005, the
2 Commission shall submit to the President and the Congress a
3 report that contains a detailed proposal (including specific leg-
4 islative or administrative recommendations, if any) and such
5 other recommendations as the Commission deems appropriate.

6 (e) SUPPORT.—The Secretary shall provide the Commis-
7 sion with the administrative support services necessary for the
8 Commission to carry out its responsibilities under this section.

9 (f) TERMINATION.—The Commission shall terminate 30
10 days after the date of submission of the report under sub-
11 section (d).

12 **TITLE II—MEDICARE ENHANCED**
13 **FEE-FOR-SERVICE AND MEDI-**
14 **CARE ADVANTAGE PROGRAMS;**
15 **MEDICARE COMPETITION**

16 **SEC. 200. MEDICARE MODERNIZATION AND REVITALIZA-**
17 **TION.**

18 This title provides for—

19 (1) establishment of the medicare enhanced fee-for-
20 service (EFFS) program under which medicare bene-
21 ficiaries are provided access to a range of enhanced fee-for-
22 service (EFFS) plans that may use preferred provider net-
23 works to offer an enhanced range of benefits;

24 (2) establishment of a Medicare Advantage program
25 that offers improved managed care plans with coordinated
26 care; and

27 (3) competitive bidding, in the style of the Federal
28 Employees Health Benefits program (FEHBP), among en-
29 hanced fee-for-service plans and Medicare Advantage plans
30 in order to promote greater efficiency and responsiveness to
31 medicare beneficiaries.

**Subtitle A—Medicare Enhanced Fee-
for-Service Program**

SEC. 201. ESTABLISHMENT OF ENHANCED FEE-FOR-SERVICE (EFFS) PROGRAM UNDER MEDICARE.

(a) IN GENERAL.—Title XVIII, as amended by section 101(a), is amended—

(1) by redesignating part E as part F; and

(2) by inserting after part D the following new part:

“PART E—ENHANCED FEE-FOR-SERVICE PROGRAM

“OFFERING OF ENHANCED FEE-FOR-SERVICE PLANS

THROUGHOUT THE UNITED STATES

“SEC. 1860E–1. (a) ESTABLISHMENT OF PROGRAM.—

“(1) IN GENERAL.—The Administrator shall establish under this part beginning January 1, 2006, an enhanced fee-for-service program under which enhanced fee-for-service plans (as defined in subsection (b)) are offered to EFFS-eligible individuals (as so defined) in EFFS regions throughout the United States.

“(2) EFFS REGIONS.—For purposes of this part the Administrator shall establish EFFS regions throughout the United States by dividing the entire United States into at least 10 such regions.

“(b) DEFINITIONS.—For purposes of this part:

“(1) EFFS ORGANIZATION.—The ‘EFFS organization’ means an entity that the Administrator certifies as meeting the requirements and standards applicable to such organization under this part.

“(2) ENHANCED FEE-FOR-SERVICE PLAN; EFFS PLAN.—The terms ‘enhanced fee-for-service plan’ and ‘EFFS plan’ mean health benefits coverage offered under a policy, contract, or plan by an EFFS organization pursuant to and in accordance with a contract pursuant to section 1860E–4(c), but only if the plan provides either fee-for-service coverage described in the following subparagraph (A) or preferred provider coverage described in the following subparagraph (B):

1 “(A) FEE-FOR-SERVICE COVERAGE.—The plan—
2 “(i) reimburses hospitals, physicians, and
3 other providers at a rate determined by the plan on
4 a fee-for-service basis without placing the provider
5 at financial risk;
6 “(ii) does not vary such rates for such a pro-
7 vider based on utilization relating to such provider;
8 and
9 “(iii) does not restrict the selection of pro-
10 viders among those who are lawfully authorized to
11 provide the covered services and agree to accept the
12 terms and conditions of payment established by the
13 plan.
14 “(B) PREFERRED PROVIDER COVERAGE.—The
15 plan—
16 “(i) has a network of providers that have
17 agreed to a contractually specified reimbursement
18 for covered benefits with the organization offering
19 the plan; and
20 “(ii) provides for reimbursement for all cov-
21 ered benefits regardless of whether such benefits
22 are provided within such network of providers.
23 “(3) EFFS ELIGIBLE INDIVIDUAL.—The term ‘EFFS
24 eligible individual’ means an eligible individual described in
25 section 1851(a)(3).
26 “(4) EFFS REGION.—The term ‘EFFS region’ means
27 a region established under subsection (a)(2).
28 “(c) APPLICATION OF CERTAIN ELIGIBILITY, ENROLL-
29 MENT, ETC. REQUIREMENTS.—The provisions of section 1851
30 (other than subsection (h)(4)(A)) shall apply to EFFS plans
31 offered by an EFFS organization in an EFFS region, including
32 subsection (g) (relating to guaranteed issue and renewal).
33 “OFFERING OF ENHANCED FEE-FOR-SERVICE (EFFS) PLANS
34 “SEC. 1860E–2. (a) PLAN REQUIREMENTS.—No EFFS
35 plan may be offered under this part in an EFFS region unless
36 the requirements of this part are met with respect to the plan
37 and EFFS organization offering the plan.

1 “(b) AVAILABLE TO ALL EFFS BENEFICIARIES IN THE
2 ENTIRE REGION.—With respect to an EFFS plan offered in an
3 EFFS region—

4 “(1) IN GENERAL.—The plan must be offered to all
5 EFFS-eligible individuals residing in the region.

6 “(2) ASSURING ACCESS TO SERVICES.—The plan shall
7 comply with the requirements of section 1852(d)(4).

8 “(c) BENEFITS.—

9 “(1) IN GENERAL.—Each EFFS plan shall provide to
10 members enrolled in the plan under this part benefits,
11 through providers and other persons that meet the applica-
12 ble requirements of this title and part A of title XI—

13 “(A) for the items and services described in sec-
14 tion 1852(a)(1);

15 “(B) that are uniform for the plan for all EFFS
16 eligible individuals residing in the same EFFS region;

17 “(C) that include a single deductible applicable to
18 benefits under parts A and B and include a cata-
19 strophic limit on out-of-pocket expenditures for such
20 covered benefits; and

21 “(D) that include benefits for prescription drug
22 coverage for each enrollee who elects under part D to
23 be provided qualified prescription drug coverage
24 through the plan.

25 “(2) DISAPPROVAL AUTHORITY.—The Administrator
26 shall not approve a plan of an EFFS organization if the
27 Administrator determines (pursuant to the last sentence of
28 section 1852(b)(1)(A)) that the benefits are designed to
29 substantially discourage enrollment by certain EFFS eligi-
30 ble individuals with the organization.

31 “(d) OUTPATIENT PRESCRIPTION DRUG COVERAGE.—For
32 rules concerning the offering of prescription drug coverage
33 under EFFS plans, see the amendment made by section
34 102(b)(1) of the Medicare Prescription Drug and Moderniza-
35 tion Act of 2003.

36 “(e) OTHER ADDITIONAL PROVISIONS.—The provisions of
37 section 1852 (other than subsection (a)(1)) shall apply under

1 this part to EFFE plans. For the application of chronic care
2 improvement provisions, see the amendment made by section
3 722(b).

4 “SUBMISSION OF BIDS; BENEFICIARY SAVINGS; PAYMENT OF
5 PLANS

6 “SEC. 1860E-3. (a) SUBMISSION OF BIDS.—

7 “(1) REQUIREMENT.—

8 “(A) EFFE MONTHLY BID AMOUNT.—For each
9 year (beginning with 2006), an EFFE organization
10 shall submit to the Administrator an EFFE monthly
11 bid amount for each EFFE plan offered in each region.
12 Each such bid is referred to in this section as the
13 ‘EFFE monthly bid amount’.

14 “(B) FORM.—Such bid amounts shall be sub-
15 mitted for each such plan and region in a form and
16 manner and time specified by the Administrator, and
17 shall include information described in paragraph
18 (3)(A).

19 “(2) UNIFORM BID AMOUNTS.—Each EFFE monthly
20 bid amount submitted under paragraph (1) by an EFFE
21 organization under this part for an EFFE plan in an
22 EFFE region may not vary among EFFE eligible individ-
23 uals residing in the EFFE region involved.

24 “(3) SUBMISSION OF BID AMOUNT INFORMATION BY
25 EFFE ORGANIZATIONS.—

26 “(A) INFORMATION TO BE SUBMITTED.—The in-
27 formation described in this subparagraph is as follows:

28 “(i) The EFFE monthly bid amount for provi-
29 sion of all items and services under this part, which
30 amount shall be based on average costs for a typ-
31 ical enrollee residing in the region, and the actu-
32 arial basis for determining such amount.

33 “(ii) The proportions of such bid amount that
34 are attributable to—

35 “(I) the provision of statutory non-drug
36 benefits (such portion referred to in this part

1 as the ‘unadjusted EFFS statutory non-drug
2 monthly bid amount’);

3 “(II) the provision of statutory prescrip-
4 tion drug benefits; and

5 “(III) the provision of non-statutory bene-
6 fits;

7 and the actuarial basis for determining such pro-
8 portions.

9 “(iii) Such additional information as the Ad-
10 ministrator may require to verify the actuarial
11 bases described in clauses (i) and (ii).

12 “(B) STATUTORY BENEFITS DEFINED.—For pur-
13 poses of this part:

14 “(i) The term ‘statutory non-drug benefits’
15 means benefits under section 1852(a)(1).

16 “(ii) The term ‘statutory prescription drug
17 benefits’ means benefits under part D.

18 “(iii) The term ‘statutory benefits’ means stat-
19 utory prescription drug benefits and statutory non-
20 drug benefits.

21 “(C) ACCEPTANCE AND NEGOTIATION OF BID
22 AMOUNTS.—The Administrator has the authority to ne-
23 gotiate regarding monthly bid amounts submitted
24 under subparagraph (A) (and the proportion described
25 in subparagraph (A)(ii)), and for such purpose, the Ad-
26 ministrator has negotiation authority that the Director
27 of the Office of Personnel Management has with re-
28 spect to health benefits plans under chapter 89 of title
29 5, United States Code. The Administrator may reject
30 such a bid amount or proportion if the Administrator
31 determines that such amount or proportion is not sup-
32 ported by the actuarial bases provided under subpara-
33 graph (A).

34 “(D) CONTRACT AUTHORITY.—The Administrator
35 may, taking into account the unadjusted EFFS statu-
36 tory non-drug monthly bid amounts accepted under

1 subparagraph (C), enter into contracts for the offering
2 of up to 3 EFFS plans in any region.

3 “(b) PROVISION OF BENEFICIARY SAVINGS FOR CERTAIN
4 PLANS.—

5 “(1) BENEFICIARY REBATE RULE.—

6 “(A) REQUIREMENT.—The EFFS plan shall pro-
7 vide to the enrollee a monthly rebate equal to 75 per-
8 cent of the average per capita savings (if any) de-
9 scribed in paragraph (2) applicable to the plan and
10 year involved.

11 “(B) FORM OF REBATE.—A rebate required under
12 this paragraph shall be provided—

13 “(i) through the crediting of the amount of the
14 rebate towards the EFFS monthly prescription
15 drug beneficiary premium (as defined in section
16 1860E-4(a)(3)(B)) and the EFFS monthly supple-
17 mental beneficiary premium (as defined in section
18 1860E-4(a)(3)(C));

19 “(ii) through a direct monthly payment
20 (through electronic funds transfer or otherwise); or

21 “(iii) through other means approved by the
22 Medicare Benefits Administrator,

23 or any combination thereof.

24 “(2) COMPUTATION OF AVERAGE PER CAPITA MONTH-
25 LY SAVINGS.—For purposes of paragraph (1)(A), the aver-
26 age per capita monthly savings referred to in such para-
27 graph for an EFFS plan and year is computed as follows:

28 “(A) DETERMINATION OF REGION-WIDE AVERAGE
29 RISK ADJUSTMENT.—

30 “(i) IN GENERAL.—The Medicare Benefits Ad-
31 ministrator shall determine, at the same time rates
32 are promulgated under section 1853(b)(1) (begin-
33 ning with 2006), for each EFFS region the average
34 of the risk adjustment factors described in sub-
35 section (c)(3) to be applied to enrollees under this
36 part in that region. In the case of an EFFS region
37 in which an EFFS plan was offered in the previous

1 year, the Administrator may compute such average
2 based upon risk adjustment factors applied under
3 subsection (c)(3) in that region in a previous year.

4 “(ii) TREATMENT OF NEW REGIONS.—In the
5 case of a region in which no EFFS plan was of-
6 fered in the previous year, the Administrator shall
7 estimate such average. In making such estimate,
8 the Administrator may use average risk adjustment
9 factors applied to comparable EFFS regions or ap-
10 plied on a national basis.

11 “(B) DETERMINATION OF RISK ADJUSTED BENCH-
12 MARK AND RISK-ADJUSTED BID.—For each EFFS plan
13 offered in an EFFS region, the Administrator shall—

14 “(i) adjust the EFFS region-specific non-drug
15 monthly benchmark amount (as defined in para-
16 graph (3)) by the applicable average risk adjust-
17 ment factor computed under subparagraph (A);
18 and

19 “(ii) adjust the unadjusted EFFS statutory
20 non-drug monthly bid amount by such applicable
21 average risk adjustment factor.

22 “(C) DETERMINATION OF AVERAGE PER CAPITA
23 MONTHLY SAVINGS.—The average per capita monthly
24 savings described in this subparagraph is equal to the
25 amount (if any) by which—

26 “(i) the risk-adjusted benchmark amount com-
27 puted under subparagraph (B)(i), exceeds

28 “(ii) the risk-adjusted bid computed under
29 subparagraph (B)(ii).

30 “(3) COMPUTATION OF EFFS REGION-SPECIFIC NON-
31 DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of
32 this part, the term ‘EFFS region-specific non-drug monthly
33 benchmark amount’ means, with respect to an EFFS re-
34 gion for a month in a year, an amount equal to $\frac{1}{12}$ of the
35 average (weighted by number of EFFS eligible individuals
36 in each payment area described in section 1853(d)) of the

1 annual capitation rate as calculated under section
2 1853(c)(1) for that area.

3 “(c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

4 “(1) NON-DRUG BENEFITS.—Under a contract under
5 section 1860E–4(c) and subject to section 1853(g) (as
6 made applicable under subsection (d)), the Administrator
7 shall make monthly payments under this subsection in ad-
8 vance to each EFFS organization, with respect to coverage
9 of an individual under this part in an EFFS region for a
10 month, in an amount determined as follows:

11 “(A) PLANS WITH BIDS BELOW BENCHMARK.—In
12 the case of a plan for which there are average per cap-
13 ita monthly savings described in subsection (b)(2)(C),
14 the payment under this subsection is equal to the
15 unadjusted EFFS statutory non-drug monthly bid
16 amount, adjusted under paragraphs (3) and (4), plus
17 the amount of the monthly rebate computed under sub-
18 section (b)(1)(A) for that plan and year.

19 “(B) PLANS WITH BIDS AT OR ABOVE BENCH-
20 MARK.—In the case of a plan for which there are no
21 average per capita monthly savings described in sub-
22 section (b)(2)(C), the payment amount under this sub-
23 section is equal to the EFFS region-specific non-drug
24 monthly benchmark amount, adjusted under para-
25 graphs (3) and (4).

26 “(2) FOR FEDERAL DRUG SUBSIDIES.—In the case in
27 which an enrollee who elects under part D to be provided
28 qualified prescription drug coverage through the plan, the
29 EFFS organization offering such plan also is entitled—

30 “(A) to direct subsidy payment under section
31 1860D–8(a)(1);

32 “(B) to reinsurance subsidy payments under sec-
33 tion 1860D–8(a)(2); and

34 “(C) to reimbursement for premium and cost-shar-
35 ing reductions for low-income individuals under section
36 1860D–7(c)(3).

1 “(3) DEMOGRAPHIC RISK ADJUSTMENT, INCLUDING
2 ADJUSTMENT FOR HEALTH STATUS.—The Administrator
3 shall adjust under paragraph (1)(A) the unadjusted EFFS
4 statutory non-drug monthly bid amount and under para-
5 graph (1)(B) the EFFS region-specific non-drug monthly
6 benchmark amount for such risk factors as age, disability
7 status, gender, institutional status, and such other factors
8 as the Administrator determines to be appropriate, includ-
9 ing adjustment for health status under section 1853(a)(3)
10 (as applied under subsection (d)), so as to ensure actuarial
11 equivalence. The Administrator may add to, modify, or sub-
12 stitute for such adjustment factors if such changes will im-
13 prove the determination of actuarial equivalence.

14 “(4) ADJUSTMENT FOR INTRA-REGIONAL GEOGRAPHIC
15 VARIATIONS.—The Administrator shall also adjust such
16 amounts in a manner to take into account variations in
17 payments rates under part C among the different payment
18 areas under such part included in each EFFS region.

19 “(d) APPLICATION OF ADDITIONAL PAYMENT RULES.—
20 The provisions of section 1853 (other than subsections
21 (a)(1)(A), (d), and (e)) shall apply to an EFFS plan under this
22 part, except as otherwise provided in this section.

23 “PREMIUMS; ORGANIZATIONAL AND FINANCIAL REQUIREMENTS;
24 ESTABLISHMENT OF STANDARDS; CONTRACTS WITH EFFS
25 ORGANIZATIONS

26 “SEC. 1860E-4. (a) PREMIUMS.—

27 “(1) IN GENERAL.—The provisions of section 1854
28 (other than subsections (a)(6)(C) and (h)), including sub-
29 section (b)(5) relating to the consolidation of drug and non-
30 drug beneficiary premiums and subsection (c) relating to
31 uniform bids and premiums, shall apply to an EFFS plan
32 under this part, subject to paragraph (2).

33 “(2) CROSS-WALK.—In applying paragraph (1), any
34 reference in section 1854(b)(1)(A) or 1854(d) to—

35 “(A) a Medicare Advantage monthly basic bene-
36 fiary premium is deemed a reference to the EFFS

1 monthly basic beneficiary premium (as defined in para-
2 graph (3)(A));

3 “(B) a Medicare Advantage monthly prescription
4 drug beneficiary premium is deemed a reference to the
5 EFFS monthly prescription drug beneficiary premium
6 (as defined in paragraph (3)(B)); and

7 “(C) a Medicare Advantage monthly supplemental
8 beneficiary premium is deemed a reference to the
9 EFFS monthly supplemental beneficiary premium (as
10 defined in paragraph (3)(C)).

11 “(3) DEFINITIONS.—For purposes of this part:

12 “(A) EFFS MONTHLY BASIC BENEFICIARY PRE-
13 MIUM.—The term ‘EFFS monthly basic beneficiary
14 premium’ means, with respect to an EFFS plan—

15 “(i) described in section 1860E–3(c)(1)(A)
16 (relating to plans providing rebates), zero; or

17 “(ii) described in section 1860E–3(c)(1)(B),
18 the amount (if any) by which the unadjusted
19 EFFS statutory non-drug monthly bid amount ex-
20 ceeds the EFFS region-specific non-drug monthly
21 benchmark amount (as defined in section 1860E–
22 3(b)(3)).

23 “(B) EFFS MONTHLY PRESCRIPTION DRUG BENE-
24 FICIARY PREMIUM.—The term ‘EFFS monthly pre-
25 scription drug beneficiary premium’ means, with re-
26 spect to an EFFS plan, the portion of the aggregate
27 monthly bid amount submitted under clause (i) of sec-
28 tion 1860E–3(a)(3)(A) for the year that is attributable
29 under such section to the provision of statutory pre-
30 scription drug benefits.

31 “(C) EFFS MONTHLY SUPPLEMENTAL BENE-
32 FICIARY PREMIUM.—The term ‘EFFS monthly supple-
33 mental beneficiary premium’ means, with respect to an
34 EFFS plan, the portion of the aggregate monthly bid
35 amount submitted under clause (i) of section 1860E–
36 3(a)(3)(A) for the year that is attributable under such
37 section to the provision of nonstatutory benefits.

1 “(b) ORGANIZATIONAL AND FINANCIAL REQUIRE-
2 MENTS.—The provisions of section 1855 shall apply to an
3 EFFS plan offered by an EFFS organization under this part.

4 “(c) CONTRACTS WITH EFFS ORGANIZATIONS.—The pro-
5 visions of section 1857 shall apply to an EFFS plan offered by
6 an EFFS organization under this part, except that any ref-
7 erence in such section to part C is deemed a reference to this
8 part.”.

9 (b) PROHIBITION ON COVERAGE UNDER MEDIGAP PLANS
10 OF DEDUCTIBLE IMPOSED UNDER EFFS PLANS.—Section
11 1882 (42 U.S.C. 1395ss), as amended by section 104(a), is
12 amended by adding at the end the following new subsection:

13 “(w) PROHIBITION ON COVERAGE OF DEDUCTIBLE AND
14 CERTAIN COST-SHARING IMPOSED UNDER EFFS PLANS.—
15 Notwithstanding any other provision of law, no medicare sup-
16 plemental policy (other than the 2 benefit packages described
17 in subsection (v)(3)) may provide for coverage of the single de-
18 ductible or more than 50 percent of other cost-sharing imposed
19 under an EFFS plan under part E.”.

20 (c) CONFORMING PROVISIONS.—Section 1882 of the Social
21 Security Act (42 U.S.C. 1395ss) shall be administered as if any
22 reference to a Medicare+Choice organization offering a
23 Medicare+Choice plan under part C of title XVIII of such Act
24 were a reference both to a Medicare Advantage organization of-
25 fering a Medicare Advantage plan under such part and an
26 EFFS organization offering an EFFS plan under part E of
27 such title.

28 **Subtitle B—Medicare Advantage** 29 **Program**

30 **CHAPTER 1—IMPLEMENTATION OF PROGRAM**

31 **SEC. 211. IMPLEMENTATION OF MEDICARE ADVANTAGE** 32 **PROGRAM.**

33 (a) IN GENERAL.—There is hereby established the Medi-
34 care Advantage program. The Medicare Advantage program
35 shall consist of the program under part C of title XVIII of the
36 Social Security Act, as amended by this title.

(b) REFERENCES.—Any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to “Medicare+Choice” is deemed a reference to “Medicare Advantage”.

SEC. 212. MEDICARE ADVANTAGE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS WITH FEE-FOR-SERVICE.—Section 1853(c)(1) (42 U.S.C. 1395w-23(c)(1)) is amended by striking subparagraph (A) and inserting the following:

“(A) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

“(i) IN GENERAL.—For 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare Advantage payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare Advantage under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

“(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.”.

(b) INCREASING MINIMUM PERCENTAGE INCREASE TO NATIONAL GROWTH RATE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w-23(c)(1)) is amended—

1 (A) in subparagraph (B)(iv), by striking “and
2 each succeeding year” and inserting “, 2003, and
3 2004”;

4 (B) in subparagraph (C)(iv), by striking “and each
5 succeeding year” and inserting “and 2003”; and

6 (C) by adding at the end of subparagraph (C) the
7 following new clause:

8 “(v) For 2004 and each succeeding year, the
9 greater of—

10 “(I) 102 percent of the annual Medicare
11 Advantage capitation rate under this paragraph
12 for the area for the previous year; or

13 “(II) the annual Medicare Advantage capi-
14 tation rate under this paragraph for the area
15 for the previous year increased by the national
16 per capita Medicare Advantage growth percent-
17 age, described in paragraph (6) for that suc-
18 ceeding year, but not taking into account for
19 any adjustment under paragraph (6)(C) for a
20 year before 2004.”.

21 (2) CONFORMING AMENDMENT.—Section
22 1853(c)(6)(C) (42 U.S.C. 1395w-23(c)(6)(C)) is amended
23 by inserting before the period at the end the following: “,
24 except that for purposes of paragraph (1)(C)(v)(II), no
25 such adjustment shall be made for a year before 2004”.

26 (c) MEDPAC STUDY OF AAPCC.—

27 (1) STUDY.—The Medicare Payment Advisory Com-
28 mission shall conduct a study that assesses the method
29 used for determining the adjusted average per capita cost
30 (AAPCC) under section 1876(a)(4) of the Social Security
31 Act (42 U.S.C. 1395mm(a)(4)) as applied under section
32 1853(c)(1)(A) of such Act (as amended by subsection (a)).
33 Such study shall include an examination of—

34 (A) the bases for variation in such costs between
35 different areas, including differences in input prices,
36 utilization, and practice patterns;

(B) the appropriate geographic area for payment under the Medicare Advantage program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

(d) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE ADVANTAGE PLANS.—Not later than July 1, 2006, the Medicare Benefits Administrator shall submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and BIPA) on the availability of Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

CHAPTER 2—IMPLEMENTATION OF COMPETITION PROGRAM

SEC. 221. COMPETITION PROGRAM BEGINNING IN 2006.

(a) SUBMISSION OF EFFS-LIKE BIDDING INFORMATION BEGINNING IN 2006.—Section 1854 (42 U.S.C. 1395w-24) is amended—

(1) by amending the section heading to read as follows:

“PREMIUMS AND BID AMOUNT”;

(2) in subsection (a)(1)(A)—

(A) by striking “(A)” and inserting “(A)(i) if the following year is before 2006,”; and

(B) by inserting before the semicolon at the end the following: “or (ii) if the following year is 2006 or later, the information described in paragraph (3) or (6)(A) for the type of plan involved”; and

1 (3) by adding at the end of subsection (a) the fol-
2 lowing:

3 “(6) SUBMISSION OF BID AMOUNTS BY MEDICARE AD-
4 VANTAGE ORGANIZATIONS.—

5 “(A) INFORMATION TO BE SUBMITTED.—The in-
6 formation described in this subparagraph is as follows:

7 “(i) The monthly aggregate bid amount for
8 provision of all items and services under this part,
9 which amount shall be based on average costs for
10 a typical enrollee residing in the area, and the ac-
11 tuarial basis for determining such amount.

12 “(ii) The proportions of such bid amount that
13 are attributable to—

14 “(I) the provision of statutory non-drug
15 benefits (such portion referred to in this part
16 as the ‘unadjusted Medicare Advantage statu-
17 tory non-drug monthly bid amount’);

18 “(II) the provision of statutory prescrip-
19 tion drug benefits; and

20 “(III) the provision of non-statutory bene-
21 fits;

22 and the actuarial basis for determining such pro-
23 portions.

24 “(iii) Such additional information as the Ad-
25 ministrator may require to verify the actuarial
26 bases described in clauses (i) and (ii).

27 “(B) STATUTORY BENEFITS DEFINED.—For pur-
28 poses of this part:

29 “(i) The term ‘statutory non-drug benefits’
30 means benefits under section 1852(a)(1).

31 “(ii) The term ‘statutory prescription drug
32 benefits’ means benefits under part D.

33 “(iii) The term ‘statutory benefits’ means stat-
34 utory prescription drug benefits and statutory non-
35 drug benefits.

36 “(C) ACCEPTANCE AND NEGOTIATION OF BID
37 AMOUNTS.—

100

1 “(i) IN GENERAL.—Subject to clause (ii)—

2 “(I) the Administrator has the authority
3 to negotiate regarding monthly bid amounts
4 submitted under subparagraph (A) (and the
5 proportion described in subparagraph (A)(ii)),
6 and for such purpose and subject to such
7 clause, the Administrator has negotiation au-
8 thority that the Director of the Office of Per-
9 sonnel Management has with respect to health
10 benefits plans under chapter 89 of title 5,
11 United States Code; and

12 “(II) the Administrator may reject such a
13 bid amount or proportion if the Administrator
14 determines that such amount or proportion is
15 not supported by the actuarial bases provided
16 under subparagraph (A).

17 “(ii) EXCEPTION.—In the case of a plan de-
18 scribed in section 1851(a)(2)(C), the provisions of
19 clause (i) shall not apply and the provisions of
20 paragraph (5)(B), prohibiting the review, approval,
21 or disapproval of amounts described in such para-
22 graph, shall apply to the negotiation and rejection
23 of the monthly bid amounts and proportion re-
24 ferred to in subparagraph (A).”.

25 (b) PROVIDING FOR BENEFICIARY SAVINGS FOR CERTAIN
26 PLANS.—

27 (1) IN GENERAL.—Section 1854(b) (42 U.S.C.
28 1395w-24(b)) is amended—

29 (A) by adding at the end of paragraph (1) the fol-
30 lowing new subparagraph:

31 “(C) BENEFICIARY REBATE RULE.—

32 “(i) REQUIREMENT.—The Medicare Advan-
33 tage plan shall provide to the enrollee a monthly re-
34 bate equal to 75 percent of the average per capita
35 savings (if any) described in paragraph (3) applica-
36 ble to the plan and year involved.

1 “(iii) FORM OF REBATE.—A rebate required
2 under this subparagraph shall be provided—

3 “(I) through the crediting of the amount
4 of the rebate towards the Medicare Advantage
5 monthly supplementary beneficiary premium or
6 the premium imposed for prescription drug cov-
7 erage under part D;

8 “(II) through a direct monthly payment
9 (through electronic funds transfer or other-
10 wise); or

11 “(III) through other means approved by
12 the Medicare Benefits Administrator,
13 or any combination thereof.”; and

14 (B) by adding at the end the following new para-
15 graphs:

16 “(3) COMPUTATION OF AVERAGE PER CAPITA MONTH-
17 LY SAVINGS.—For purposes of paragraph (1)(C)(i), the av-
18 erage per capita monthly savings referred to in such para-
19 graph for a Medicare Advantage plan and year is computed
20 as follows:

21 “(A) DETERMINATION OF STATE-WIDE AVERAGE
22 RISK ADJUSTMENT.—

23 “(i) IN GENERAL.—The Medicare Benefits Ad-
24 ministrator shall determine, at the same time rates
25 are promulgated under section 1853(b)(1) (begin-
26 ning with 2006), for each State the average of the
27 risk adjustment factors to be applied under section
28 1853(a)(1)(A) to payment for enrollees in that
29 State. In the case of a State in which a Medicare
30 Advantage plan was offered in the previous year,
31 the Administrator may compute such average based
32 upon risk adjustment factors applied in that State
33 in a previous year.

34 “(ii) TREATMENT OF NEW STATES.—In the
35 case of a State in which no Medicare Advantage
36 plan was offered in the previous year, the Adminis-
37 trator shall estimate such average. In making such

1 estimate, the Administrator may use average risk
2 adjustment factors applied to comparable States or
3 applied on a national basis.

4 “(B) DETERMINATION OF RISK ADJUSTED BENCH-
5 MARK AND RISK-ADJUSTED BID.—For each Medicare
6 Advantage plan offered in a State, the Administrator
7 shall—

8 “(i) adjust the fee-for-service area-specific
9 non-drug monthly benchmark amount (as defined
10 in subsection (j)) by the applicable average risk ad-
11 justment factor computed under subparagraph (A);
12 and

13 “(ii) adjust the unadjusted Medicare Advan-
14 tage statutory non-drug monthly bid amount by
15 such applicable average risk adjustment factor.

16 “(C) DETERMINATION OF AVERAGE PER CAPITA
17 MONTHLY SAVINGS.—The average per capita monthly
18 savings described in this subparagraph is equal to the
19 amount (if any) by which—

20 “(i) the risk-adjusted benchmark amount com-
21 puted under subparagraph (B)(i), exceeds

22 “(ii) the risk-adjusted bid computed under
23 subparagraph (B)(ii).

24 “(D) AUTHORITY TO DETERMINE RISK ADJUST-
25 MENT FOR AREAS OTHER THAN STATES.—The Admin-
26 istrator may provide for the determination and applica-
27 tion of risk adjustment factors under this paragraph on
28 the basis of areas other than States.

29 “(4) BENEFICIARY’S OPTION OF PAYMENT THROUGH
30 WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE
31 OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In ac-
32 cordance with regulations, a Medicare Advantage organiza-
33 tion shall permit each enrollee, at the enrollee’s option, to
34 make payment of premiums under this part to the organi-
35 zation indirectly through withholding from benefit pay-
36 ments in the manner provided under section 1840 with re-
37 spect to monthly premiums under section 1839 or through

1 an electronic funds transfer mechanism (such as automatic
2 charges of an account at a financial institution or a credit
3 or debit card account) or otherwise.”.

4 (2) PROVISION OF SINGLE CONSOLIDATED PRE-
5 MIUM.—Section 1854(b) (42 U.S.C. 1395w-24(b)), as
6 amended by paragraph (1), is further amended by adding
7 at the end the following new paragraph:

8 “(5) SINGLE CONSOLIDATED PREMIUM.—In the case
9 of an enrollee in a Medicare Advantage plan who elects
10 under part D to be provided qualified prescription drug
11 coverage through the plan, the Administrator shall provide
12 a mechanism for the consolidation of the beneficiary pre-
13 mium amount for non-drug benefits under this part with
14 the premium amount for prescription drug coverage under
15 part D provided through the plan.”.

16 (3) COMPUTATION OF FEE-FOR-SERVICE AREA-SPE-
17 CIFIC NON-DRUG BENCHMARK.—Section 1853 (42 U.S.C.
18 1395w-23) is amended by adding at the end the following
19 new subsection:

20 “(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC
21 NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes
22 of this part, the term ‘fee-for-service area-specific non-drug
23 monthly benchmark amount’ means, with respect to a Medicare
24 Advantage payment area for a month in a year, an amount
25 equal to $\frac{1}{12}$ of the annual Medicare Advantage capitation rate
26 under section 1853(c)(1) for the area for the year.”.

27 (c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

28 (1) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C.
29 1395w-23) is amended by striking “in an amount” and all
30 that follows and inserting the following: “in an amount de-
31 termined as follows:

32 “(i) PAYMENT BEFORE 2006.—For years be-
33 fore 2006, the payment amount shall be equal to
34 $\frac{1}{12}$ of the annual Medicare Advantage capitation
35 rate (as calculated under subsection (c)(1)) with re-
36 spect to that individual for that area, reduced by

1 the amount of any reduction elected under section
2 1854(f)(1)(E) and adjusted under clause (iv).

3 “(ii) PAYMENT FOR STATUTORY NON-DRUG
4 BENEFITS BEGINNING WITH 2006.—For years be-
5 ginning with 2006—

6 “(I) PLANS WITH BIDS BELOW BENCH-
7 MARK.—In the case of a plan for which there
8 are average per capita monthly savings de-
9 scribed in section 1854(b)(3)(C), the payment
10 under this subsection is equal to the
11 unadjusted Medicare Advantage statutory non-
12 drug monthly bid amount, adjusted under
13 clause (iv), plus the amount of the monthly re-
14 bate computed under section 1854(b)(1)(C)(i)
15 for that plan and year.

16 “(II) PLANS WITH BIDS AT OR ABOVE
17 BENCHMARK.—In the case of a plan for which
18 there are no average per capita monthly sav-
19 ings described in section 1854(b)(3)(C), the
20 payment amount under this subsection is equal
21 to the fee-for-service area-specific non-drug
22 monthly benchmark amount, adjusted under
23 clause (iv).

24 “(iii) FOR FEDERAL DRUG SUBSIDIES.—In the
25 case in which an enrollee who elects under part D
26 to be provided qualified prescription drug coverage
27 through the plan, the Medicare Advantage organi-
28 zation offering such plan also is entitled—

29 “(I) to direct subsidy payment under sec-
30 tion 1860D–8(a)(1);

31 “(II) to reinsurance subsidy payments
32 under section 1860D–8(a)(2); and

33 “(III) to reimbursement for premium and
34 cost-sharing reductions for low-income individ-
35 uals under section 1860D–7(c)(3).

36 “(iv) DEMOGRAPHIC ADJUSTMENT, INCLUDING
37 ADJUSTMENT FOR HEALTH STATUS.—The Admin-

1 istrator shall adjust the payment amount under
2 clause (i), the unadjusted Medicare Advantage stat-
3 utory non-drug monthly bid amount under clause
4 (ii)(I), and the fee-for-service area-specific non-
5 drug monthly benchmark amount under clause
6 (ii)(II) for such risk factors as age, disability sta-
7 tus, gender, institutional status, and such other
8 factors as the Administrator determines to be ap-
9 propriate, including adjustment for health status
10 under paragraph (3), so as to ensure actuarial
11 equivalence. The Administrator may add to, mod-
12 ify, or substitute for such adjustment factors if
13 such changes will improve the determination of ac-
14 tuarial equivalence.”.

15 (d) CONFORMING AMENDMENTS.—

16 (1) PROTECTION AGAINST BENEFICIARY SELECTION.—

17 Section 1852(b)(1)(A) (42 U.S.C. 1395w–22(b)(1)(A)) is
18 amended by adding at the end the following: “The Admin-
19 istrator shall not approve a plan of an organization if the
20 Administrator determines that the benefits are designed to
21 substantially discourage enrollment by certain Medicare
22 Advantage eligible individuals with the organization.”.

23 (2) CONFORMING AMENDMENT TO PREMIUM TERMI-
24 NOLOGY.—Section 1854(b)(2) (42 U.S.C. 1395w–24(b)(2))
25 is amended by redesignating subparagraph (C) as subpara-
26 graph (D) and by striking subparagraphs (A) and (B) and
27 inserting the following:

28 “(A) MEDICARE ADVANTAGE MONTHLY BASIC
29 BENEFICIARY PREMIUM.—The term ‘Medicare Advan-
30 tage monthly basic beneficiary premium’ means, with
31 respect to a Medicare Advantage plan—

32 “(i) described in section 1853(a)(1)(A)(ii)(I)
33 (relating to plans providing rebates), zero; or

34 “(ii) described in section 1853(a)(1)(A)(ii)(II),
35 the amount (if any) by which the unadjusted Medi-
36 care Advantage statutory non-drug monthly bid

1 amount exceeds the fee-for-service area-specific
2 non-drug monthly benchmark amount;
3 except that, in the case of a Medicare Advantage pri-
4 vate fee-for-service plan, such term means such pre-
5 mium as the plan files with the Administrator under
6 this section.

7 “(B) MEDICARE ADVANTAGE MONTHLY PRESCRIP-
8 TION DRUG BENEFICIARY PREMIUM.—The term ‘Medi-
9 care Advantage monthly prescription drug beneficiary
10 premium’ means, with respect to a Medicare Advantage
11 plan, that portion of the bid amount submitted under
12 clause (i) of subsection (a)(6)(A) for the year that is
13 attributable under such section to the provision of stat-
14 utory prescription drug benefits.

15 “(C) MEDICARE ADVANTAGE MONTHLY SUPPLE-
16 MENTAL BENEFICIARY PREMIUM.—The term ‘Medicare
17 Advantage monthly supplemental beneficiary premium’
18 means, with respect to a Medicare Advantage plan, the
19 portion of the aggregate monthly bid amount submitted
20 under clause (i) of subsection (a)(6)(A) for the year
21 that is attributable under such section to the provision
22 of nonstatutory benefits.”.

23 (3) REQUIREMENT FOR UNIFORM PREMIUM AND BID
24 AMOUNTS.—Section 1854(c) (42 U.S.C. 1395w–24(c)) is
25 amended to read as follows:

26 “(c) UNIFORM PREMIUM AND BID AMOUNTS.—The Medi-
27 care Advantage monthly bid amount submitted under sub-
28 section (a)(6), the Medicare Advantage monthly basic, prescrip-
29 tion drug, and supplemental beneficiary premiums, and the
30 Medicare Advantage monthly MSA premium charged under
31 subsection (b) of a Medicare Advantage organization under this
32 part may not vary among individuals enrolled in the plan.”.

33 (4) PERMITTING BENEFICIARY REBATES.—

34 (A) Section 1851(h)(4)(A) (42 U.S.C. 1395w–
35 21(h)(4)(A)) is amended by inserting “except as pro-
36 vided under section 1854(b)(1)(C)” after “or other-
37 wise”.

(B) Section 1854(d) (42 U.S.C. 1395w-24(d)) is amended by inserting “, except as provided under subsection (b)(1)(C),” after “and may not provide”.

(5) OTHER CONFORMING AMENDMENTS RELATING TO BIDS.—Section 1854 (42 U.S.C. 1395w-24) is amended—

(A) in the heading of subsection (a), by inserting “AND BID AMOUNTS” after “PREMIUMS”; and

(B) in subsection (a)(5)(A), by inserting “paragraphs (2), (3), and (4) of” after “filed under”.

(e) ADDITIONAL CONFORMING AMENDMENTS.—

(1) ANNUAL DETERMINATION AND ANNOUNCEMENT OF CERTAIN FACTORS.—Section 1853(b)(1) (42 U.S.C. 1395w-23(b)(1)) is amended by striking “the respective calendar year” and all that follows and inserting the following: “the calendar year concerned with respect to each Medicare Advantage payment area, the following:

“(A) PRE-COMPETITION INFORMATION.—For years before 2006, the following:

“(i) MEDICARE ADVANTAGE CAPITATION RATES.—The annual Medicare Advantage capitation rate for each Medicare Advantage payment area for the year.

“(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

“(B) COMPETITION INFORMATION.—For years beginning with 2006, the following:

“(i) BENCHMARK.—The fee-for-service area-specific non-drug benchmark under section 1853(j).

“(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iv) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).”.

1 (2) REPEAL OF PROVISIONS RELATING TO ADJUSTED
2 COMMUNITY RATE (ACR).—

3 (A) IN GENERAL.—Subsections (e) and (f) of sec-
4 tion 1854 (42 U.S.C. 1395w–24) are repealed.

5 (B) CONFORMING AMENDMENTS.—(i) Section
6 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by
7 striking “, and to reflect” and all that follows and in-
8 serting a period.

9 (ii) Section 1852(a)(1) (42 U.S.C. 1395w–
10 22(a)(1)) is amended by striking “title XI” and all that
11 follows and inserting the following: “title XI those
12 items and services (other than hospice care) for which
13 benefits are available under parts A and B to individ-
14 uals residing in the area served by the plan.”.

15 (iii) Section 1857(d)(1) (42 U.S.C. 1395w–
16 27(d)(1)) is amended by striking “, costs, and com-
17 putation of the adjusted community rate” and inserting
18 “and costs”.

19 (f) REFERENCES UNDER PART E.—Section 1859 (42
20 U.S.C. 1395w–29) is amended by adding at the end the fol-
21 lowing new subsection:

22 “(f) APPLICATION UNDER PART E.—In the case of any
23 reference under part E to a requirement or provision of this
24 part in the relation to an EFFS plan or organization under
25 such part, except as otherwise specified any such requirement
26 or provision shall be applied to such organization or plan in the
27 same manner as such requirement or provision applies to a
28 Medicare Advantage private fee-for-service plan (and the Medi-
29 care Advantage organization that offers such plan) under this
30 part.”.

31 (g) EFFECTIVE DATE.—The amendments made by this
32 section shall apply to payments and premiums for months be-
33 ginning with January 2006.

CHAPTER 3—ADDITIONAL REFORMS**SEC. 231. MAKING PERMANENT CHANGE IN MEDICARE
ADVANTAGE REPORTING DEADLINES AND
ANNUAL, COORDINATED ELECTION PERIOD.**

(a) CHANGE IN REPORTING DEADLINE.—Section 1854(a)(1) (42 U.S.C. 1395w-24(a)(1)), as amended by section 532(b)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking “2002, 2003, and 2004 (or July 1 of each other year)” and inserting “2002 and each subsequent year”.

(b) DELAY IN ANNUAL, COORDINATED ELECTION PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w-21(e)(3)(B)), as amended by section 532(c)(1)(A) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking “and after 2005”; and

(2) by striking “, 2004, and 2005” and inserting “and any subsequent year”.

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(1) (42 U.S.C. 1395w-23(b)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking “and after 2005”; and

(2) by striking “and 2005” and inserting “and each subsequent year”.

(d) REQUIRING PROVISION OF AVAILABLE INFORMATION COMPARING PLAN OPTIONS.—The first sentence of section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w-21(d)(2)(A)(ii)) is amended by inserting before the period the following: “to the extent such information is available at the time of preparation of materials for the mailing”.

SEC. 232. AVOIDING DUPLICATIVE STATE REGULATION.

(a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w-26(b)(3)) is amended to read as follows:

“(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State

1 laws relating to plan solvency) with respect to Medicare Ad-
2 vantage plans which are offered by Medicare Advantage or-
3 ganizations under this part.”.

4 (b) EFFECTIVE DATE.—The amendment made by sub-
5 section (a) shall take effect on the date of the enactment of this
6 Act.

7 **SEC. 233. SPECIALIZED MEDICARE ADVANTAGE PLANS**
8 **FOR SPECIAL NEEDS BENEFICIARIES.**

9 (a) TREATMENT AS COORDINATED CARE PLAN.—Section
10 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by
11 adding at the end the following new sentence: “Specialized
12 Medicare Advantage plans for special needs beneficiaries (as
13 defined in section 1859(b)(4)) may be any type of coordinated
14 care plan.”.

15 (b) SPECIALIZED MEDICARE ADVANTAGE PLAN FOR SPE-
16 CIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42
17 U.S.C. 1395w–29(b)) is amended by adding at the end the fol-
18 lowing new paragraph:

19 “(4) SPECIALIZED MEDICARE ADVANTAGE PLANS FOR
20 SPECIAL NEEDS BENEFICIARIES.—

21 “(A) IN GENERAL.—The term ‘specialized Medi-
22 care Advantage plan for special needs beneficiaries’
23 means a Medicare Advantage plan that exclusively
24 serves special needs beneficiaries (as defined in sub-
25 paragraph (B)).

26 “(B) SPECIAL NEEDS BENEFICIARY.—The term
27 ‘special needs beneficiary’ means a Medicare Advantage
28 eligible individual who—

29 “(i) is institutionalized (as defined by the Sec-
30 retary);

31 “(ii) is entitled to medical assistance under a
32 State plan under title XIX; or

33 “(iii) meets such requirements as the Sec-
34 retary may determine would benefit from enroll-
35 ment in such a specialized Medicare Advantage
36 plan described in subparagraph (A) for individuals
37 with severe or disabling chronic conditions.”.

1 (c) RESTRICTION ON ENROLLMENT PERMITTED.—Section
2 1859 (42 U.S.C. 1395w–29) is amended by adding at the end
3 the following new subsection:

4 “(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED
5 MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS BENE-
6 FICIARIES.—In the case of a specialized Medicare Advantage
7 plan (as defined in subsection (b)(4)), notwithstanding any
8 other provision of this part and in accordance with regulations
9 of the Secretary and for periods before January 1, 2007, the
10 plan may restrict the enrollment of individuals under the plan
11 to individuals who are within one or more classes of special
12 needs beneficiaries.”.

13 (d) REPORT TO CONGRESS.—Not later than December 31,
14 2005, the Medicare Benefits Administrator shall submit to
15 Congress a report that assesses the impact of specialized Medi-
16 care Advantage plans for special needs beneficiaries on the cost
17 and quality of services provided to enrollees. Such report shall
18 include an assessment of the costs and savings to the medicare
19 program as a result of amendments made by subsections (a),
20 (b), and (c).

21 (e) EFFECTIVE DATES.—

22 (1) IN GENERAL.—The amendments made by sub-
23 sections (a), (b), and (c) shall take effect upon the date of
24 the enactment of this Act.

25 (2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR
26 SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later
27 than 6 months after the date of the enactment of this Act,
28 the Secretary of Health and Human Services shall issue
29 final regulations to establish requirements for special needs
30 beneficiaries under section 1859(b)(4)(B)(iii) of the Social
31 Security Act, as added by subsection (b).

32 **SEC. 234. MEDICARE MSAS.**

33 (a) EXEMPTION FROM REPORTING ENROLLEE ENCOUN-
34 TER DATA.—

35 (1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C.
36 1395w–22(e)(1)) is amended by inserting “(other than
37 MSA plans)” after “plans”.

1 (2) CONFORMING AMENDMENTS.—Section 1852 (42
2 U.S.C. 1395w-22) is amended—

3 (A) in subsection (c)(1)(I), by inserting before the
4 period at the end the following: “if required under such
5 section”; and

6 (B) in subparagraphs (A) and (B) of subsection
7 (e)(2), by striking “, a non-network MSA plan,” and
8 “, NON-NETWORK MSA PLANS,” each place it appears.

9 (b) MAKING PROGRAM PERMANENT AND ELIMINATING
10 CAP.—Section 1851(b)(4) (42 U.S.C. 1395w-21(b)(4)) is
11 amended—

12 (1) in the heading, by striking “ON A DEMONSTRATION
13 BASIS”;

14 (2) by striking the first sentence of subparagraph (A);
15 and

16 (3) by striking the second sentence of subparagraph
17 (C).

18 (c) APPLYING LIMITATIONS ON BALANCE BILLING.—Sec-
19 tion 1852(k)(1) (42 U.S.C. 1395w-22(k)(1)) is amended by in-
20 serting “or with an organization offering a MSA plan” after
21 “section 1851(a)(2)(A)”.

22 (d) ADDITIONAL AMENDMENT.—Section 1851(e)(5)(A)
23 (42 U.S.C. 1395w-21(e)(5)(A)) is amended—

24 (1) by adding “or” at the end of clause (i);

25 (2) by striking “, or” at the end of clause (ii) and in-
26 serting a semicolon; and

27 (3) by striking clause (iii).

28 **SEC. 235. EXTENSION OF REASONABLE COST CON-**
29 **TRACTS.**

30 Subparagraph (C) of section 1876(h)(5) (42 U.S.C.
31 1395mm(h)(5)) is amended to read as follows:

32 “(C)(i) Subject to clause (ii), may be extended or renewed
33 under this subsection indefinitely.

34 “(ii) For any period beginning on or after January 1,
35 2008, a reasonable cost reimbursement contract under this sub-
36 section may not be extended or renewed for a service area inso-
37 far as such area, during the entire previous year, was within

1 the service area of 2 or more plans which were coordinated care
2 Medicare Advantage plans under part C or 2 or more enhanced
3 fee-for-service plans under part E and each of which plan for
4 that previous year for the area involved meets the following
5 minimum enrollment requirements:

6 “(I) With respect to any portion of the area involved
7 that is within a Metropolitan Statistical Area with a popu-
8 lation of more than 250,000 and counties contiguous to
9 such Metropolitan Statistical Area, 5,000 individuals.

10 “(II) With respect to any other portion of such area,
11 1,500 individuals.”.

12 **Subtitle C—Application of FEHBP-** 13 **Style Competitive Reforms**

14 **SEC. 241. APPLICATION OF FEHBP-STYLE COMPETITIVE** 15 **REFORM BEGINNING IN 2010.**

16 (a) IDENTIFICATION OF COMPETITIVE EFFS REGIONS;
17 COMPUTATION OF COMPETITIVE EFFS NON-DRUG BENCH-
18 MARKS UNDER EFFS PROGRAM.—

19 (1) IN GENERAL.—Section 1860E–3, as added by sec-
20 tion 201(a), is amended by adding at the end the following
21 new subsection:

22 “(e) APPLICATION OF COMPETITION.—

23 “(1) DETERMINATION OF COMPETITIVE EFFS RE-
24 GIONS.—For purposes of this part, the term ‘competitive
25 EFFS region’ means, for a year beginning with 2010, an
26 EFFS region that the Administrator finds there will be of-
27 fered during the annual, coordinated election period under
28 section 1851(e)(3)(B) (as applied under section 1860E–
29 1(c)) before the beginning of the year at least 2 EFFS
30 plans (in addition to the fee-for-service program under
31 parts A and B), each offered by a different EFFS organi-
32 zation and each of which met the minimum enrollment re-
33 quirements of paragraph (1) of section 1857(b) (as applied
34 without regard to paragraph (3) thereof) as of March of
35 the previous year.

36 “(2) COMPETITIVE EFFS NON-DRUG MONTHLY BENCH-
37 MARK AMOUNT.—For purposes of this part, the term ‘com-

petitive EFFS non-drug monthly benchmark amount’ means, with respect to an EFFS region for a month in a year, the sum of the 2 components described in paragraph (3) for the region and year. The Administrator shall compute such benchmark amount for each competitive EFFS region before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which it is designated as such a region.

“(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for an EFFS region and a year are the following:

“(A) EFFS COMPONENT.—The product of the following:

“(i) WEIGHTED AVERAGE OF PLAN BIDS IN REGION.—The weighted average of the EFFS plan bids for the region and year (as determined under paragraph (4)(A)).

“(ii) NON-FFS MARKET SHARE.—1 minus the fee-for-service market share percentage determined under paragraph (5) for the region and the year.

“(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

“(i) EFFS REGION-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNT.—The EFFS region-specific non-drug monthly benchmark amount (as defined in subsection (b)(3)) for the region and year.

“(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage (determined under paragraph (5)) for the region and the year.

“(4) DETERMINATION OF WEIGHTED AVERAGE EFFS PLAN BIDS FOR A REGION.—

“(A) IN GENERAL.—For purposes of paragraph (3)(A)(i), the weighted average of EFFS plan bids for an EFFS region and a year is the sum of the following

1 products for EFFS plans described in subparagraph
2 (C) in the region and year:

3 “(i) UNADJUSTED EFFS STATUTORY NON-
4 DRUG MONTHLY BID AMOUNT.—The unadjusted
5 EFFS statutory non-drug monthly bid amount (as
6 defined in subsection (a)(3)(A)(ii)(I)) for the region
7 and year.

8 “(ii) PLAN’S SHARE OF EFFS ENROLLMENT IN
9 REGION.—The number of individuals described in
10 subparagraph (B), divided by the total number of
11 such individuals for all EFFS plans described in
12 subparagraph (C) for that region and year.

13 “(B) COUNTING OF INDIVIDUALS.—The Adminis-
14 trator shall count, for each EFFS plan described in
15 subparagraph (C) for an EFFS region and year, the
16 number of individuals who reside in the region and who
17 were enrolled under such plan under this part during
18 March of the previous year.

19 “(C) EXCLUSION OF PLANS NOT OFFERED IN PRE-
20 VIOUS YEAR.—For an EFFS region and year, the
21 EFFS plans described in this subparagraph are plans
22 that are offered in the region and year and were of-
23 fered in the region in March of the previous year.

24 “(5) COMPUTATION OF FEE-FOR-SERVICE MARKET
25 SHARE PERCENTAGE.—The Administrator shall determine,
26 for a year and an EFFS region, the proportion (in this
27 subsection referred to as the ‘fee-for-service market share
28 percentage’) of the EFFS eligible individuals who are resi-
29 dents of the region during March of the previous year, of
30 such individuals who were not enrolled in an EFFS plan
31 or in a Medicare Advantage plan (or, if greater, such pro-
32 portion determined for individuals nationally).

33 “(6) APPLICATION OF COMPETITION.—In the case of
34 an EFFS region that is a competitive EFFS region for a
35 year, for purposes of applying subsections (b) and (c)(1)
36 and section 1860E–4(a), any reference to an EFFS region-
37 specific non-drug monthly benchmark amount shall be

1 treated as a reference to the competitive EFFS non-drug
2 monthly benchmark amount under paragraph (2) for the
3 region and year.”.

4 (2) CONFORMING AMENDMENTS.—

5 (A) Such section 1860E–3 is further amended—

6 (i) in subsection (b), by adding at the end the
7 following new paragraph:

8 “(4) APPLICATION IN COMPETITIVE REGIONS.—

9 For special rules applying this subsection in competi-
10 tive EFFS regions, see subsection (e)(6).”;

11 (ii) in subsection (c)(1), by inserting “and
12 subsection (e)(1)” after “(as made applicable under
13 subsection (d))”; and

14 (iii) in subsection (d) , by striking “and (e)”
15 and inserting “(e), and (k) ”.

16 (B) Section 1860E–4(a), as inserted by section
17 201(a)(2), is amended by inserting “, except as pro-
18 vided in section 1860E–3(e)(6)” after “under this
19 part”.

20 (b) IDENTIFICATION OF COMPETITIVE AREAS; APPLICA-
21 TION OF COMPETITIVE MEDICARE ADVANTAGE NON-DRUG
22 BENCHMARKS UNDER MEDICARE ADVANTAGE PROGRAM.—

23 (1) IN GENERAL.—Section 1853, as amended by sec-
24 tion 221(b)(3), is amended by adding at the end the fol-
25 lowing new subsection:

26 “(k) APPLICATION OF COMPETITION.—

27 “(1) DETERMINATION OF COMPETITIVE MEDICARE AD-
28 VANTAGE AREAS.—For purposes of this part, the terms
29 ‘competitive Medicare Advantage area’ and ‘CMA area’
30 mean, for a year beginning with 2010, an area that the Ad-
31 ministrator finds there will be offered during the annual,
32 coordinated election period under section 1851(e)(3)(B)
33 under this part before the beginning of the year at least
34 2 Medicare Advantage plans (in addition to the fee-for-
35 service program under parts A and B), each offered by a
36 different Medicare Advantage organization and each of
37 which met the minimum enrollment requirements of para-

graph (1) of section 1857(b) (as applied without regard to paragraph (3) thereof) as of March of the previous year with respect to the area.

“(2) COMPETITIVE MEDICARE ADVANTAGE NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term ‘competitive Medicare Advantage non-drug monthly benchmark amount’ means, with respect to a competitive Medicare Advantage area for a month in a year, the sum of the 2 components described in paragraph (3) for the area and year. The Administrator shall compute such benchmark amount for each competitive Medicare Advantage area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which it is designated as such an area.

“(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for a competitive Medicare Advantage area and a year are the following:

“(A) MEDICARE ADVANTAGE COMPONENT.—The product of the following:

“(i) WEIGHTED AVERAGE OF MEDICARE ADVANTAGE PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (4)(A)).

“(ii) NON-FFS MARKET SHARE.—1 minus the fee-for-service market share percentage, determined under paragraph (6) for the area and year.

“(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

“(i) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BID.—The fee-for-service area-specific non-drug bid (as defined in paragraph (5)) for the area and year.

“(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage, determined under paragraph (6) for the area and year.

1 “(4) DETERMINATION OF WEIGHTED AVERAGE MEDI-
2 CARE ADVANTAGE BIDS FOR AN AREA.—

3 “(A) IN GENERAL.—For purposes of paragraph
4 (3)(A)(i), the weighted average of plan bids for an area
5 and a year is the sum of the following products for
6 Medicare Advantage plans described in subparagraph
7 (C) in the area and year:

8 “(i) MONTHLY MEDICARE ADVANTAGE STATU-
9 TORY NON-DRUG BID AMOUNT.—The unadjusted
10 Medicare Advantage statutory non-drug monthly
11 bid amount.

12 “(ii) PLAN’S SHARE OF MEDICARE ADVANTAGE
13 ENROLLMENT IN AREA.—The number of individ-
14 uals described in subparagraph (B), divided by the
15 total number of such individuals for all Medicare
16 Advantage plans described in subparagraph (C) for
17 that area and year.

18 “(B) COUNTING OF INDIVIDUALS.—The Adminis-
19 trator shall count, for each Medicare Advantage plan
20 described in subparagraph (C) for an area and year,
21 the number of individuals who reside in the area and
22 who were enrolled under such plan under this part dur-
23 ing March of the previous year.

24 “(C) EXCLUSION OF PLANS NOT OFFERED IN PRE-
25 VIOUS YEAR.—For an area and year, the Medicare Ad-
26 vantage plans described in this subparagraph are plans
27 described in the first sentence of section 1851(a)(2)(A)
28 that are offered in the area and year and were offered
29 in the area in March of the previous year.

30 “(5) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG
31 BID.—For purposes of this subsection, the term ‘fee-for-
32 service area-specific non-drug bid’ means, for an area and
33 year, the weighted average of the amounts described in sec-
34 tion 1853(j) for Medicare Advantage payment area or areas
35 included in the area (based on the number of traditional
36 fee-for-service enrollees in such payment area or areas) and
37 year.

1 “(6) COMPUTATION OF FEE-FOR-SERVICE MARKET
2 SHARE PERCENTAGE.—The Administrator shall determine,
3 for a year and a competitive Medicare Advantage area, the
4 proportion (in this subsection referred to as the ‘fee-for-
5 service market share percentage’) of Medicare Advantage
6 eligible individuals residing in the area who during March
7 of the previous year were not enrolled in a Medicare Advan-
8 tage plan or in an EFFS plan (or, if greater, such propor-
9 tion determined for individuals nationally).

10 “(7) APPLICATION OF COMPETITION.—In the case of
11 an area that is a competitive Medicare Advantage area for
12 a year, for purposes of applying subsection (a)(1)(A)(iii)
13 and sections 1854(b)(2)(A)(ii) and 1854(b)(3)(B)(i), any
14 reference to a fee-for-service area-specific non-drug monthly
15 benchmark amount shall be treated as a reference to the
16 competitive Medicare Advantage non-drug monthly bench-
17 mark amount under paragraph (2) for the area and year.

18 (2) APPLICATION.—Section 1854 (42 U.S.C. 1395w-
19 24) is amended—

20 (A) in subsection (b)(1)(C)(i), as added by section
21 221(b)(1)(A), by striking “(i) REQUIREMENT.—The”
22 and inserting “(i) REQUIREMENT FOR NON-COMPETI-
23 TIVE AREAS.—In the case of a Medicare Advantage
24 payment area that is not a competitive Medicare Ad-
25 vantage area designated under section 1853(k)(1),
26 the”;

27 (B) in subsection (b)(1)(C), as so added, by insert-
28 ing after clause (i) the following new clause:

29 “(ii) REQUIREMENT FOR COMPETITIVE MEDI-
30 CARE ADVANTAGE AREAS.—In the case of a Medi-
31 care Advantage payment area that is designated as
32 a competitive Medicare Advantage area under sec-
33 tion 1853(k)(1), if there are average per capita
34 monthly savings described in paragraph (6) for a
35 Medicare Advantage plan and year, the Medicare
36 Advantage plan shall provide to the enrollee a

1 monthly rebate equal to 75 percent of such sav-
2 ings.”; and

3 (C) by adding at the end of subsection (b), as
4 amended by sections 221(b)(1)(B) and 221(b)(2), the
5 following new paragraph:

6 “(6) COMPUTATION OF AVERAGE PER CAPITA MONTH-
7 LY SAVINGS FOR COMPETITIVE MEDICARE ADVANTAGE
8 AREAS.—For purposes of paragraph (1)(C)(ii), the average
9 per capita monthly savings referred to in such paragraph
10 for a Medicare Advantage plan and year shall be computed
11 in the same manner as the average per capita monthly sav-
12 ings is computed under paragraph (3) except that the ref-
13 erence to the fee-for-service area-specific non-drug monthly
14 benchmark amount in paragraph (3)(B)(i) (or to the
15 benchmark amount as adjusted under paragraph (3)(C)(i))
16 is deemed to be a reference to the competitive Medicare Ad-
17 vantage non-drug monthly benchmark amount (or such
18 amount as adjusted in the manner described in paragraph
19 (3)(B)(i)).”.

20 (3) ADDITIONAL CONFORMING AMENDMENTS.—

21 (A) PAYMENT OF PLANS.—Section
22 1853(a)(1)(A)(ii), as amended by section 221(c)(1), is
23 amended—

24 (i) in subclauses (I) and (II), by inserting
25 “(or, insofar as such payment area is a competitive
26 Medicare Advantage area, described in section
27 1854(b)(6))” after “section 1854(b)(3)(C)”; and

28 (ii) in subclause (II), by inserting “(or, insofar
29 as such payment area is a competitive Medicare
30 Advantage area, the competitive Medicare Advan-
31 tage non-drug monthly benchmark amount)” after
32 “fee-for-service area-specific non-drug monthly
33 benchmark amount”; and

34 (B) DISCLOSURE OF INFORMATION.—Section
35 1853(b)(1)(B), as amended by section 221(e)(1), is
36 amended to read as follows:

1 “(B) COMPETITION INFORMATION.—For years be-
2 ginning with 2006, the following:

3 “(i) BENCHMARKS.—The fee-for-service area-
4 specific non-drug benchmark under section 1853(j)
5 and, if applicable, the competitive Medicare Advan-
6 tage non-drug benchmark under section
7 1853(k)(2), for the year and competitive Medicare
8 Advantage area involved and the fee-for-service
9 market share percentage for the area and year.

10 “(ii) ADJUSTMENT FACTORS.—The adjust-
11 ment factors applied under section
12 1853(a)(1)(A)(iv) (relating to demographic adjust-
13 ment), section 1853(a)(1)(B) (relating to adjust-
14 ment for end-stage renal disease), and section
15 1853(a)(3) (relating to health status adjustment).

16 “(iii) PROJECTED FEE-FOR-SERVICE BID.—In
17 the case of a competitive Medicare Advantage area,
18 the projected fee-for-service area-specific non-drug
19 bid (as determined under subsection (k)(5)) for the
20 area.

21 “(iv) INDIVIDUALS.—The number of individ-
22 uals counted under subsection (k)(4)(B) and en-
23 rolled in each Medicare Advantage plan in the
24 area.”.

25 (C) DEFINITION OF MONTHLY BASIC PREMIUM.—
26 Section 1854(b)(2)(A)(ii), as amended by section
27 221(d)(2), is amended by inserting “(or, in the case of
28 a competitive Medicare Advantage area, the competitive
29 Medicare Advantage non-drug monthly benchmark
30 amount or, in applying this paragraph under part E in
31 the case of a competitive EFFS region, the competitive
32 EFFS non-drug monthly benchmark amount)” after
33 “benchmark amount”.

34 (c) PREMIUM ADJUSTMENT.—

35 (1) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is
36 amended by adding at the end the following new sub-
37 section:

1 “(h)(1) In the case of an individual who resides in a com-
2 petitive Medicare Advantage area under section 1853(k)(1) (re-
3 gardless of whether such area is in a competitive EFFS region
4 under section 1860E-3(e)) and who is not enrolled in a Medi-
5 care Advantage plan under part C or in an EFFS plan under
6 part E, the monthly premium otherwise applied under this part
7 (determined without regard to subsections (b) and (f) or any
8 adjustment under this subsection) shall be adjusted as follows:
9 If the fee-for-service area-specific non-drug bid (as defined in
10 section 1853(k)(5)) for the competitive Medicare Advantage
11 area in which the individual resides for a month—

12 “(A) does not exceed the competitive Medicare Advan-
13 tage non-drug benchmark (as determined under section
14 1853(k)(2)) for such area, the amount of the premium for
15 the individual for the month shall be reduced by an amount
16 equal to 75 percent of the amount by which such bench-
17 mark exceeds such fee-for-service bid; or

18 “(B) exceeds such competitive Medicare Advantage
19 non-drug benchmark, the amount of the premium for the
20 individual for the month shall be adjusted to ensure that—

21 “(i) the sum of the amount of the adjusted pre-
22 mium and the competitive Medicare Advantage non-
23 drug benchmark for the area, is equal to

24 “(ii) the sum of the unadjusted premium plus
25 amount of the fee-for-service area-specific non-drug bid
26 for the area.

27 “(2) In the case of an individual who resides in an area
28 that is within a competitive EFFS region under section
29 1860E-3(e) but is not within a competitive Medicare Advan-
30 tage area under section 1853(k)(1) and who is not enrolled in
31 a Medicare Advantage plan under part C or in an EFFS plan
32 under part E, the monthly premium otherwise applied under
33 this part (determined without regard to subsections (b) and (f)
34 or any adjustment under this subsection) shall be adjusted as
35 follows: If the EFFS region-specific non-drug monthly bench-
36 mark amount (as defined in section 1860E-3(b)(3)) for a re-
37 gion for a month—

1 “(A) does not exceed the competitive EFFS non-drug
2 monthly benchmark amount (as determined under section
3 1860E–3(e)(2)) for such region, the amount of the pre-
4 mium for the individual for the month shall be reduced by
5 an amount equal to 75 percent of the amount by which
6 such competitive benchmark amount exceeds such region-
7 specific benchmark amount; or

8 “(B) exceeds such competitive EFFS non-drug month-
9 ly benchmark amount, the amount of the premium for the
10 individual for the month shall be adjusted to ensure that—

11 “(i) the sum of the amount of the adjusted pre-
12 mium and the competitive EFFS non-drug monthly
13 benchmark amount for the region, is equal to

14 “(ii) the sum of the unadjusted premium plus the
15 amount of the EFFS region-specific non-drug monthly
16 benchmark amount for the region.

17 “(3) Nothing in this subsection shall be construed as pre-
18 venting a reduction under paragraph (1)(A) or paragraph
19 (2)(A) in the premium otherwise applicable under this part to
20 zero or from requiring the provision of a rebate to the extent
21 such premium would otherwise be required to be less than zero.

22 “(4) The adjustment in the premium under this subsection
23 shall be effected in such manner as the Medicare Benefits Ad-
24 ministrator determines appropriate.

25 “(5) In order to carry out this subsection (insofar as it is
26 effected through the manner of collection of premiums under
27 1840(a)), the Medicare Benefits Administrator shall transmit
28 to the Commissioner of Social Security—

29 “(A) at the beginning of each year, the name, social
30 security account number, and the amount of the adjust-
31 ment (if any) under this subsection for each individual en-
32 rolled under this part for each month during the year; and

33 “(B) periodically throughout the year, information to
34 update the information previously transmitted under this
35 paragraph for the year.”.

36 (2) CONFORMING AMENDMENT.—Section 1844(c) (42
37 U.S.C. 1395w(c)) is amended by inserting “and without re-

1 gard to any premium adjustment effected under section
2 1839(h)” before the period at the end.

3 (d) EFFECTIVE DATE.—The amendments made by this
4 section shall take effect on January 1, 2010.

5 **TITLE III—COMBATTING WASTE,**
6 **FRAUD, AND ABUSE**

7 **SEC. 301. MEDICARE SECONDARY PAYOR (MSP) PROVI-**
8 **SIONS.**

9 (a) TECHNICAL AMENDMENT CONCERNING SECRETARY’S
10 AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CER-
11 TAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

12 (1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C.
13 1395y(b)(2)) is amended—

14 (A) in subparagraph (A)(ii), by striking “promptly
15 (as determined in accordance with regulations)”;

16 (B) in subparagraph (B)—

17 (i) by redesignating clauses (i) through (iii) as
18 clauses (ii) through (iv), respectively; and

19 (ii) by inserting before clause (ii), as so redesi-
20 gnated, the following new clause:

21 “(i) AUTHORITY TO MAKE CONDITIONAL PAY-
22 MENT.—The Secretary may make payment under
23 this title with respect to an item or service if a pri-
24 mary plan described in subparagraph (A)(ii) has
25 not made or cannot reasonably be expected to make
26 payment with respect to such item or service
27 promptly (as determined in accordance with regula-
28 tions). Any such payment by the Secretary shall be
29 conditioned on reimbursement to the appropriate
30 Trust Fund in accordance with the succeeding pro-
31 visions of this subsection.”.

32 (2) EFFECTIVE DATE.—The amendments made by
33 paragraph (1) shall be effective as if included in the enact-
34 ment of title III of the Medicare and Medicaid Budget Rec-
35 onciliation Amendments of 1984 (Public Law 98-369).

1 (b) CLARIFYING AMENDMENTS TO CONDITIONAL PAY-
2 MENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C.
3 1395y(b)(2)) is further amended—

4 (1) in subparagraph (A), in the matter following
5 clause (ii), by inserting the following sentence at the end:
6 “An entity that engages in a business, trade, or profession
7 shall be deemed to have a self-insured plan if it carries its
8 own risk (whether by a failure to obtain insurance, or oth-
9 erwise) in whole or in part.”;

10 (2) in subparagraph (B)(ii), as redesignated by sub-
11 section (a)(2)(B)—

12 (A) by striking the first sentence and inserting the
13 following: “A primary plan, and an entity that receives
14 payment from a primary plan, shall reimburse the ap-
15 propriate Trust Fund for any payment made by the
16 Secretary under this title with respect to an item or
17 service if it is demonstrated that such primary plan has
18 or had a responsibility to make payment with respect
19 to such item or service. A primary plan’s responsibility
20 for such payment may be demonstrated by a judgment,
21 a payment conditioned upon the recipient’s com-
22 promise, waiver, or release (whether or not there is a
23 determination or admission of liability) of payment for
24 items or services included in a claim against the pri-
25 mary plan or the primary plan’s insured, or by other
26 means.”; and

27 (B) in the final sentence, by striking “on the date
28 such notice or other information is received” and in-
29 serting “on the date notice of, or information related
30 to, a primary plan’s responsibility for such payment or
31 other information is received”; and

32 (3) in subparagraph (B)(iii), , as redesignated by sub-
33 section (a)(2)(B), by striking the first sentence and insert-
34 ing the following: “In order to recover payment made under
35 this title for an item or service, the United States may
36 bring an action against any or all entities that are or were
37 required or responsible (directly, as an insurer or self-in-

1 surer, as a third-party administrator, as an employer that
2 sponsors or contributes to a group health plan, or large
3 group health plan, or otherwise) to make payment with re-
4 spect to the same item or service (or any portion thereof)
5 under a primary plan. The United States may, in accord-
6 ance with paragraph (3)(A) collect double damages against
7 any such entity. In addition, the United States may recover
8 under this clause from any entity that has received pay-
9 ment from a primary plan or from the proceeds of a pri-
10 mary plan's payment to any entity.”.

11 (c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C.
12 1395y(b)) is amended—

13 (1) in paragraph (1)(A), by moving the indentation of
14 clauses (ii) through (v) 2 ems to the left; and

15 (2) in paragraph (3)(A), by striking “such” before
16 “paragraphs”.

17 **SEC. 302. COMPETITIVE ACQUISITION OF CERTAIN**
18 **ITEMS AND SERVICES.**

19 (a) IN GENERAL.—Section 1847 (42 U.S.C. 1395w-3) is
20 amended to read as follows:

21 “COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

22 “SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE AC-
23 QUISSION PROGRAMS.—

24 “(1) IMPLEMENTATION OF PROGRAMS.—

25 “(A) IN GENERAL.—The Secretary shall establish
26 and implement programs under which competitive ac-
27 quisition areas are established throughout the United
28 States for contract award purposes for the furnishing
29 under this part of competitively priced items and serv-
30 ices (described in paragraph (2)) for which payment is
31 made under this part. Such areas may differ for dif-
32 ferent items and services.

33 “(B) PHASED-IN IMPLEMENTATION.—The pro-
34 grams shall be phased-in—

35 “(i) among competitive acquisition areas over
36 a period of not longer than 3 years in a manner

1 so that the competition under the programs occurs
2 in—

3 “(I) at least $\frac{1}{3}$ of such areas in 2005; and

4 “(II) at least $\frac{2}{3}$ of such areas in 2006;

5 and

6 “(ii) among items and services in a manner
7 such that the programs apply to the highest cost
8 and highest volume items and services first.

9 “(C) WAIVER OF CERTAIN PROVISIONS.—In car-
10 rying out the programs, the Secretary may waive such
11 provisions of the Federal Acquisition Regulation as are
12 necessary for the efficient implementation of this sec-
13 tion, other than provisions relating to confidentiality of
14 information and such other provisions as the Secretary
15 determines appropriate.

16 “(2) ITEMS AND SERVICES DESCRIBED.—The items
17 and services referred to in paragraph (1) are the following:

18 “(A) DURABLE MEDICAL EQUIPMENT AND MED-
19 ICAL SUPPLIES.—Covered items (as defined in section
20 1834(a)(13)) for which payment is otherwise made
21 under section 1834(a), including items used in infusion
22 and drugs and supplies used in conjunction with dura-
23 ble medical equipment, but excluding class III devices
24 under the Federal Food, Drug, and Cosmetic Act.

25 “(B) OTHER EQUIPMENT AND SUPPLIES.—Items,
26 equipment, and supplies (as described in section
27 1842(s)(2)(D) other than enteral nutrients).

28 “(C) OFF-THE-SHELF ORTHOTICS.—Orthotics (de-
29 scribed in section 1861(s)(9)) for which payment is
30 otherwise made under section 1834(h) which require
31 minimal self-adjustment for appropriate use and does
32 not require expertise in trimming, bending, molding,
33 assembling, or customizing to fit to the patient.

34 “(3) EXCEPTION AUTHORITY.—In carrying out the
35 programs under this section, the Secretary may exempt—

36 “(A) rural areas and areas with low population
37 density within urban areas that are not competitive,

1 unless there is a significant national market through
2 mail order for a particular item or service; and

3 “(B) items and services for which the application
4 of competitive acquisition is not likely to result in sig-
5 nificant savings.

6 “(4) SPECIAL RULE FOR CERTAIN RENTED ITEMS OF
7 DURABLE MEDICAL EQUIPMENT.—In the case of a covered
8 item for which payment is made on a rental basis under
9 section 1834(a), the Secretary shall establish a process by
10 which rental agreements for the covered items entered into
11 before the application of the competitive acquisition pro-
12 gram under this section for the item may be continued not-
13 withstanding this section. In the case of any such continu-
14 ation, the supplier involved shall provide for appropriate
15 servicing and replacement, as required under section
16 1834(a).

17 “(5) PHYSICIAN AUTHORIZATION.—The Secretary may
18 establish a process under which a physician may prescribe
19 a particular brand or mode of delivery of an item or service
20 if the item or service involved is clinically more appropriate
21 than other similar items or services.

22 “(6) APPLICATION.—For each competitive acquisition
23 area in which the program is implemented under this sub-
24 section with respect to items and services, the payment
25 basis determined under the competition conducted under
26 subsection (b) shall be substituted for the payment basis
27 otherwise applied under section 1834(a).

28 “(b) PROGRAM REQUIREMENTS.—

29 “(1) IN GENERAL.—The Secretary shall conduct a
30 competition among entities supplying items and services de-
31 scribed in subsection (a)(2) for each competitive acquisition
32 area in which the program is implemented under subsection
33 (a) with respect to such items and services.

34 “(2) CONDITIONS FOR AWARDED CONTRACT.—

35 “(A) IN GENERAL.—The Secretary may not award
36 a contract to any entity under the competition con-
37 ducted in an competitive acquisition area pursuant to

1 paragraph (1) to furnish such items or services unless
2 the Secretary finds all of the following:

3 “(i) The entity meets quality and financial
4 standards specified by the Secretary or developed
5 by the Program Advisory and Oversight Committee
6 established under subsection (c).

7 “(ii) The total amounts to be paid under the
8 contract (including costs associated with the ad-
9 ministration of the contract) are expected to be less
10 than the total amounts that would otherwise be
11 paid.

12 “(iii) Beneficiary access to a choice of multiple
13 suppliers in the area is maintained.

14 “(iv) Beneficiary liability is limited to 20 per-
15 cent of the applicable contract award price, except
16 in such cases where a supplier has furnished an up-
17 graded item and has executed an advanced bene-
18 ficiary notice.

19 “(B) DEVELOPMENT OF QUALITY STANDARDS FOR
20 DME PRODUCTS.—

21 “(i) IN GENERAL.—The quality standards
22 specified under subparagraph (A)(i) shall not be
23 less than the quality standards that would other-
24 wise apply if this section did not apply and shall
25 include consumer services standards. Not later than
26 July 1, 2004, the Secretary shall establish new
27 quality standards for products subject to competi-
28 tive acquisition under this section. Such standards
29 shall be applied prospectively and shall be published
30 on the website of the Department of Health and
31 Human Services.

32 “(ii) CONSULTATION WITH PROGRAM ADVI-
33 SORY AND OVERSIGHT COMMITTEE.—The Secretary
34 shall consult with the Program Advisory and Over-
35 sight Committee (established under subsection (c))
36 to review (and advise the Secretary concerning) the
37 quality standards referred to in clause (i).

1 “(3) CONTENTS OF CONTRACT.—

2 “(A) IN GENERAL.—A contract entered into with
3 an entity under the competition conducted pursuant to
4 paragraph (1) is subject to terms and conditions that
5 the Secretary may specify.

6 “(B) TERM OF CONTRACTS.—The Secretary shall
7 recompile contracts under this section not less often
8 than once every 3 years.

9 “(4) LIMIT ON NUMBER OF CONTRACTORS.—

10 “(A) IN GENERAL.—The Secretary may limit the
11 number of contractors in a competitive acquisition area
12 to the number needed to meet projected demand for
13 items and services covered under the contracts. In
14 awarding contracts, the Secretary shall take into ac-
15 count the ability of bidding entities to furnish items or
16 services in sufficient quantities to meet the anticipated
17 needs of beneficiaries for such items or services in the
18 geographic area covered under the contract on a timely
19 basis.

20 “(B) MULTIPLE WINNERS.—The Secretary shall
21 award contracts to multiple entities submitting bids in
22 each area for an item or service.

23 “(5) PAYMENT.—Payment under this part for com-
24 petitively priced items and services described in subsection
25 (a)(2) shall be based on the bids submitted and accepted
26 under this section for such items and services.

27 “(6) PARTICIPATING CONTRACTORS.—Payment shall
28 not be made for items and services described in subsection
29 (a)(2) furnished by a contractor and for which competition
30 is conducted under this section unless—

31 “(A) the contractor has submitted a bid for such
32 items and services under this section; and

33 “(B) the Secretary has awarded a contract to the
34 contractor for such items and services under this sec-
35 tion.

36 In this section, the term ‘bid’ means a request for a pro-
37 posal for an item or service that includes the cost of the

1 item or service, and where appropriate, any services that
2 are attendant to the provision of the item or service.

3 “(7) CONSIDERATION IN DETERMINING CATEGORIES
4 FOR BIDS.—The Secretary shall consider the similarity of
5 the clinical efficiency and value of specific codes and prod-
6 ucts, including products that may provide a therapeutic ad-
7 vantage to beneficiaries, before delineating the categories
8 and products that will be subject to bidding.

9 “(8) AUTHORITY TO CONTRACT FOR EDUCATION, MON-
10 ITORING, OUTREACH AND COMPLAINT SERVICES.—The Sec-
11 retary may enter into a contract with an appropriate entity
12 to address complaints from beneficiaries who receive items
13 and services from an entity with a contract under this sec-
14 tion and to conduct appropriate education of and outreach
15 to such beneficiaries and monitoring quality of services with
16 respect to the program.

17 “(c) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

18 “(1) ESTABLISHMENT.—There is established a Pro-
19 gram Advisory and Oversight Committee (hereinafter in
20 this section referred to as the ‘Committee’).

21 “(2) MEMBERSHIP; TERMS.—The Committee shall
22 consist of such members as the Secretary may appoint who
23 shall serve for such term as the Secretary may specify.

24 “(3) DUTIES.—

25 “(A) TECHNICAL ASSISTANCE.—The Committee
26 shall provide advice and technical assistance to the Sec-
27 retary with respect to the following functions:

28 “(i) The implementation of the program under
29 this section.

30 “(ii) The establishment of requirements for
31 collection of data.

32 “(iii) The development of proposals for effi-
33 cient interaction among manufacturers and dis-
34 tributors of the items and services and providers
35 and beneficiaries.

36 “(B) ADDITIONAL DUTIES.—The Committee shall
37 perform such additional functions to assist the Sec-

1 retary in carrying out this section as the Secretary may
2 specify.

3 “(4) INAPPLICABILITY OF FACA.—The provisions of
4 the Federal Advisory Committee Act (5 U.S.C. App.) shall
5 not apply.

6 “(d) ANNUAL REPORTS.—The Secretary shall submit to
7 Congress an annual management report on the programs under
8 this section. Each such report shall include information on sav-
9 ings, reductions in beneficiary cost-sharing, access to and qual-
10 ity of items and services, and beneficiary satisfaction.

11 “(e) DEMONSTRATION PROJECT FOR CLINICAL LABORA-
12 TORY SERVICES.—

13 “(1) IN GENERAL.—The Secretary shall conduct a
14 demonstration project on the application of competitive ac-
15 quisition under this section to clinical diagnostic laboratory
16 tests—

17 “(A) for which payment is otherwise made under
18 section 1833(h) or 1834(d)(1) (relating to colorectal
19 cancer screening tests); and

20 “(B) which are furnished by entities that did not
21 have a face-to-face encounter with the individual.

22 “(2) TERMS AND CONDITIONS.—Such project shall be
23 under the same conditions as are applicable to items and
24 services described in subsection (a)(2).

25 “(3) REPORT.—The Secretary shall submit to
26 Congress—

27 “(A) an initial report on the project not later than
28 December 31, 2005; and

29 “(B) such progress and final reports on the
30 project after such date as the Secretary determines ap-
31 propriate.”.

32 (b) CONFORMING AMENDMENTS.—

33 (1) DURABLE MEDICAL EQUIPMENT; ELIMINATION OF
34 INHERENT REASONABLENESS AUTHORITY.—Section
35 1834(a) (42 U.S.C. 1395m(a)) is amended—

1 (A) in paragraph (1)(B), by striking “The pay-
2 ment basis” and inserting “Subject to subparagraph
3 (E)(i), the payment basis”;

4 (B) in paragraph (1)(C), by striking “This sub-
5 section” and inserting “Subject to subparagraph
6 (E)(ii), this subsection”;

7 (C) by adding at the end of paragraph (1) the fol-
8 lowing new subparagraph:

9 “(E) APPLICATION OF COMPETITIVE ACQUISITION;
10 ELIMINATION OF INHERENT REASONABLENESS AU-
11 THORITY.—In the case of covered items and services
12 that are included in a competitive acquisition program
13 in a competitive acquisition area under section
14 1847(a)—

15 “(i) the payment basis under this subsection
16 for such items and services furnished in such area
17 shall be the payment basis determined under such
18 competitive acquisition program; and

19 “(ii) the Secretary may use information on the
20 payment determined under such competitive acqui-
21 sition programs to adjust the payment amount oth-
22 erwise recognized under subparagraph (B)(ii) for
23 an area that is not a competitive acquisition area
24 under section 1847 and in the case of such adjust-
25 ment, paragraph (10)(B) shall not be applied.”;
26 and

27 (D) in paragraph (10)(B), by inserting “in an
28 area and with respect to covered items and services for
29 which the Secretary does not make a payment amount
30 adjustment under paragraph (1)(E)” after “under this
31 subsection”.

32 (2) OFF-THE-SHELF ORTHOTICS; ELIMINATION OF IN-
33 HERENT REASONABLENESS AUTHORITY.—Section 1834(h)
34 (42 U.S.C. 1395m(h)) is amended—

35 (A) in paragraph (1)(B), by striking “and (E)”
36 and inserting “, (E) , and (H)(i)”;

(B) in paragraph (1)(D), by striking “This subsection” and inserting “Subject to subparagraph (H)(ii), this subsection”;

(C) by adding at the end of paragraph (1) the following new subparagraph:

“(H) APPLICATION OF COMPETITIVE ACQUISITION TO ORTHOTICS; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of orthotics described in paragraph (2)(B) of section 1847(a) that are included in a competitive acquisition program in a competitive acquisition area under such section—

“(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

“(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.”.

(c) REPORT ON ACTIVITIES OF SUPPLIERS.—The Secretary shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act, as amended by subsection (a), are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability.

SEC. 303. COMPETITIVE ACQUISITION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS.

(a) ADJUSTMENT TO PHYSICIAN FEE SCHEDULE.—

(1) ADJUSTMENT IN PRACTICE EXPENSE RELATIVE VALUE UNITS.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)) is amended—

1 (A) in subparagraph (B)—

2 (i) in clause (ii)(II), by striking “The adjust-
3 ments” and inserting “Subject to clause (iv), the
4 adjustments”; and

5 (ii) by adding at the end of subparagraph (B),
6 the following new clause:

7 “(iv) EXCEPTION TO BUDGET NEUTRALITY.—
8 The additional expenditures attributable to clause
9 (ii) of subparagraph (H) shall not be taken into ac-
10 count in applying clause (ii)(II) for 2004.”; and

11 (B) by adding at the end the following new sub-
12 paragraph:

13 “(H) ADJUSTMENTS IN PRACTICE EXPENSE REL-
14 ATIVE VALUE UNITS FOR 2004.—

15 “(i) IN GENERAL.—As part of the annual
16 process of establishing the physician fee schedule
17 under subsection (b) for 2004, the Secretary shall
18 increase the practice expense relative value units
19 for 2004 consistent with clause (ii).

20 “(ii) USE OF SUPPLEMENTAL SURVEY DATA.—
21 For 2004 for any specialty that submitted survey
22 data that included expenses for the administration
23 of drugs and biologicals for which payment is made
24 under section 1842(o) (or section 1847A), the Sec-
25 retary shall use such supplemental survey data in
26 carrying out this subparagraph insofar as they are
27 collected and provided by entities and organizations
28 consistent with the criteria established by the Sec-
29 retary pursuant to section 212(a) of the Medicare,
30 Medicaid, and SCHIP Balanced Budget Refine-
31 ment Act of 1999 and insofar as such data are
32 submitted to the Secretary by the date of the en-
33 actment of this subparagraph.

34 “(iii) SUBSEQUENT, BUDGET NEUTRAL AD-
35 JUSTMENTS PERMITTED.—Nothing in this subpara-
36 graph shall be construed as preventing the Sec-
37 retary from providing for adjustments in practice

1 expense relative value units under (and consistent
2 with) subparagraph (B) for years after 2004.

3 “(iv) CONSULTATION.—Before publishing the
4 notice of proposed rulemaking to carry out this
5 subparagraph, the Secretary shall consult with the
6 Comptroller General of the United States and with
7 groups representing the physician specialties in-
8 volved.

9 “(v) TREATMENT AS CHANGE IN LAW AND
10 REGULATION IN SUSTAINABLE GROWTH RATE DE-
11 TERMINATION.—The enactment of subparagraph
12 (B)(iv) and this subparagraph shall be treated as
13 a change in law for purposes of applying subsection
14 (f)(2)(D).”.

15 (2) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL
16 REVIEW.—Section 1848(i)(1) (42 U.S.C. 1395w-4(i)(1)) is
17 amended—

18 (A) by striking “and” at the end of subparagraph (D);

19 (B) by striking the period at the end of subparagraph
20 (E) and inserting “, and”; and

21 (C) by adding at the end the following new subpara-
22 graph:

23 “(F) adjustments in practice expense relative
24 value units for 2004 under subsection (c)(2)(H).”.

25 (3) TREATMENT OF OTHER SERVICES CURRENTLY IN
26 THE NON-PHYSICIAN WORK POOL.—The Secretary shall
27 make adjustments to the non-physician work pool method-
28 ology (as such term is used in the regulations promulgated
29 by the Secretary in the Federal Register as of December
30 31, 2002) for determination of practice expense relative
31 value units under the physician fee schedule described in
32 section 1848(c)(2)(C)(ii) of the Social Security Act so that
33 the practice expense relative value units for services deter-
34 mined under such methodology are not disproportionately
35 reduced relative to the practice expense relative value units
36 of other services not determined under such non-physician

1 work pool methodology, as the result of amendments made
2 by paragraph (1).

3 (b) PAYMENT BASED ON COMPETITION.—Title XVIII is
4 amended by inserting after section 1847 (42 U.S.C. 1395w–3),
5 as amended by section 302, the following new section:

6 “COMPETITIVE ACQUISITION OF COVERED OUTPATIENT DRUGS
7 AND BIOLOGICALS

8 “SEC. 1847A. (a) IMPLEMENTATION OF COMPETITIVE AC-
9 QUSITION.—

10 “(1) IMPLEMENTATION OF PROGRAM.—

11 “(A) IN GENERAL.—The Secretary shall establish
12 and implement a competitive acquisition program under
13 which—

14 “(i) competitive acquisition areas are estab-
15 lished throughout the United States for contract
16 award purposes for acquisition of and payment for
17 categories of covered outpatient drugs and
18 biologicals (as defined in paragraph (2)) under this
19 part; and

20 “(ii) each physician makes an annual selection,
21 under paragraph (5) of the contractor through
22 which drugs and biologicals within a category of
23 drugs and biologicals will be acquired and delivered
24 to the physician under this part.

25 “(B) IMPLEMENTATION.—The Secretary shall im-
26 plement the program so that the program applies to—

27 “(i) the oncology category beginning in 2005;
28 and

29 “(ii) the non-oncology category beginning in
30 2006.

31 “(C) WAIVER OF CERTAIN PROVISIONS.—In order
32 to promote competition, efficient service, and product
33 quality, in carrying out the program the Secretary may
34 waive such provisions of the Federal Acquisition Regu-
35 lation as are necessary for the efficient implementation
36 of this section, other than provisions relating to con-

1 confidentiality of information and such other provisions as
2 the Secretary determines appropriate.

3 “(D) EXCLUSION AUTHORITY.—The Secretary
4 may exclude covered outpatient drugs and biologicals
5 (including a class of such drugs and biologicals) from
6 the competitive bidding system under this section if the
7 drugs or biologicals (or class) are not appropriate for
8 competitive bidding or would not produce savings.

9 “(2) COVERED OUTPATIENT DRUGS AND BIOLOGICALS,
10 CATEGORIES, PROGRAM DEFINED.—For purposes of this
11 section—

12 “(A) COVERED OUTPATIENT DRUGS AND
13 BIOLOGICALS DEFINED.—The term ‘covered outpatient
14 drugs and biologicals’ means drugs and biologicals to
15 which section 1842(o) applies and which are not cov-
16 ered under section 1847 (relating to competitive acqui-
17 sition for items of durable medical equipment). Such
18 term does not include the following:

19 “(i) Blood clotting factors.

20 “(ii) Drugs and biologicals furnished to indi-
21 viduals in connection with the treatment of end
22 stage renal disease.

23 “(iii) Radiopharmaceuticals.

24 “(B) 2 CATEGORIES.—Each of the following shall
25 be a separate category of covered outpatient drugs and
26 biologicals, as identified by the Secretary:

27 “(i) ONCOLOGY CATEGORY.—A category (in
28 this section referred to as the ‘oncology category’)
29 consisting of those covered outpatient drugs and
30 biologicals that, as determined by the Secretary,
31 are typically primarily billed by oncologists or are
32 otherwise used to treat cancer.

33 “(ii) NON-ONCOLOGY CATEGORIES.—Such
34 numbers of categories (in this section referred to as
35 the ‘non-oncology categories’) consisting of covered
36 outpatient drugs and biologicals not described in

1 clause (i), and appropriate subcategories of such
2 drugs and biologicals as the Secretary may specify.

3 “(C) PROGRAM.—The term ‘program’ means the
4 competitive acquisition program under this section.

5 “(D) COMPETITIVE ACQUISITION AREA; AREA.—
6 The terms ‘competitive acquisition area’ and ‘area’
7 mean an appropriate geographic region established
8 specified by the Secretary under the program.

9 “(E) CONTRACTOR.—The term ‘contractor’ means
10 an entity that has entered into a contract with the Sec-
11 retary under this section.

12 “(3) APPLICATION OF PROGRAM PAYMENT METHOD-
13 OLOGY.—With respect to covered outpatient drugs and
14 biologicals which are supplied under the program in an
15 area—

16 “(A) the claim for such drugs and biologicals shall
17 be submitted by the contractor that supplied the drugs
18 and biologicals;

19 “(B) collection of amounts of any deductible and
20 coinsurance applicable with respect to such drugs and
21 biologicals shall be the responsibility of such contractor
22 and shall not be collected unless the drug or biological
23 is administered to the beneficiary involved; and

24 “(C) the payment under this section (and related
25 coinsurance amounts) for such drugs and biologicals—

26 “(i) shall be made only to such contractor;

27 “(ii) shall be conditioned upon the administra-
28 tion of such drugs and biologicals; and

29 “(iii) shall be based on the average of the bid
30 prices for such drugs and biologicals in the area, as
31 computed under subsection (d).

32 The Secretary shall provide a process for recoupment
33 in the case in which payment is made for drugs and
34 biologicals which were billed at the time of dispensing
35 but which were not actually administered.

36 “(4) CONTRACT REQUIRED.—Payment may not be
37 made under this part for covered outpatient drugs and

1 biologicals prescribed by a physician within a category and
2 a competitive acquisition area with respect to which the
3 program applies unless—

4 “(A) the drugs or biologicals are supplied by a
5 contractor with a contract under this section for such
6 category of drugs and biologicals and area; and

7 “(B) the physician has elected such contractor
8 under paragraph (5) for such category and area.

9 “(5) CONTRACTOR SELECTION PROCESS.—

10 “(A) IN GENERAL.—The Secretary shall provide a
11 process for the selection of a contractor, on an annual
12 basis and in such exigent circumstances as the Sec-
13 retary may provide and with respect to each category
14 of covered outpatient drugs and biologicals for an area,
15 by physicians prescribing such drugs and biologicals in
16 the area of the contractor under this section that will
17 supply the drugs and biologicals within that category
18 and area.

19 “(B) INFORMATION ON CONTRACTORS.—The Sec-
20 retary shall make available to physicians on an ongoing
21 basis, through a directory posted on the Department’s
22 Internet website or otherwise and upon request, a list
23 of the contractors under this section in the different
24 competitive acquisition areas.

25 “(C) SELECTING PHYSICIAN DEFINED.—For pur-
26 poses of this section, the term ‘selecting physician’
27 means, with respect to a contractor and category and
28 competitive acquisition area, a physician who has se-
29 lected to apply under this section such contractor for
30 such category and area.

31 “(b) PROGRAM REQUIREMENTS.—

32 “(1) CONTRACT FOR COVERED OUTPATIENT DRUGS
33 AND BIOLOGICALS.—The Secretary shall conduct a com-
34 petition among entities for the acquisition of a covered out-
35 patient drug or biological within each HCPCS code within
36 each category for each competitive acquisition area.

37 “(2) CONDITIONS FOR AWARDED CONTRACT.—

1 “(A) IN GENERAL.—The Secretary may not award
2 a contract to any entity under the competition con-
3 ducted in a competitive acquisition area pursuant to
4 paragraph (1) with respect to the acquisition of covered
5 outpatient drugs and biologicals within a category un-
6 less the Secretary finds that the entity meets all of the
7 following with respect to the contract period involved:

8 “(i) CAPACITY TO SUPPLY COVERED OUT-
9 PATIENT DRUG OR BIOLOGICAL WITHIN CAT-
10 EGORY.—

11 “(I) IN GENERAL.—The entity has suffi-
12 cient arrangements to acquire and to deliver
13 covered outpatient drugs and biologicals within
14 such category in the area specified in the con-
15 tract at the bid price specified in the contract
16 for all physicians that may elect such entity.

17 “(II) SHIPMENT METHODOLOGY.—The en-
18 tity has arrangements in effect for the ship-
19 ment at least 5 days each week of covered out-
20 patient drugs and biologicals under the con-
21 tract and for the timely delivery (including for
22 emergency situations) of such drugs and
23 biologicals in the area under the contract.

24 “(ii) QUALITY, SERVICE, FINANCIAL PERFORM-
25 ANCE AND SOLVENCY STANDARDS.—The entity
26 meets quality, service, financial performance, and
27 solvency standards specified by the Secretary,
28 including—

29 “(I) the establishment of procedures for
30 the prompt response and resolution of physi-
31 cian and beneficiary complaints and inquiries
32 regarding the shipment of covered outpatient
33 drugs and biologicals; and

34 “(II) a grievance process for the resolution
35 of disputes.

36 “(B) ADDITIONAL CONSIDERATIONS.—The Sec-
37 retary may refuse to award a contract under this sec-

tion, and may terminate such a contract, with an entity based upon—

“(i) the suspension or revocation, by the Federal Government or a State government, of the entity’s license for the distribution of drugs or biologicals (including controlled substances); or

“(ii) the exclusion of the entity under section 1128 from participation under this title.

“(C) APPLICATION OF MEDICARE PROVIDER OMBUDSMAN.—For provision providing for a program-wide Medicare Provider Ombudsman to review complaints, see section 1868(b), as added by section 923 of the Medicare Prescription Drug and Modernization Act of 2003.

“(3) AWARDING MULTIPLE CONTRACTS FOR A CATEGORY AND AREA.—In order to provide a choice of at least 2 contractors in each competitive acquisition area for a category of drugs and biologicals, the Secretary may limit (but not below 2) the number of qualified entities that are awarded such contracts for any category and area. The Secretary shall select among qualified entities based on the following:

“(A) The bid prices for covered outpatient drugs and biologicals within the category and area.

“(B) Bid price for distribution of such drugs and biologicals.

“(C) Ability to ensure product integrity.

“(D) Customer service.

“(E) Past experience in the distribution of drugs and biologicals, including controlled substances.

“(F) Such other factors as the Secretary may specify.

“(4) TERMS OF CONTRACTS.—

“(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify consistent with this section.

1 “(B) PERIOD OF CONTRACTS.—A contract under
2 this section shall be for a term of 2 years, but may be
3 terminated by the Secretary or the entity with appro-
4 priate, advance notice.

5 “(C) INTEGRITY OF DRUG AND BIOLOGICAL DIS-
6 TRIBUTION SYSTEM.—The Secretary—

7 “(i) shall require that for all drug and biologi-
8 cal products distributed by a contractor under this
9 section be acquired directly from the manufacturer
10 or from a distributor that has acquired the prod-
11 ucts directly from the manufacturer; and

12 “(ii) may require, in the case of such products
13 that are particularly susceptible to counterfeit or
14 diversion, that the contractor comply with such ad-
15 ditional product integrity safeguards as may be de-
16 termined to be necessary.

17 “(D) IMPLEMENTATION OF ANTI-COUNTER-
18 FEITING, QUALITY, SAFETY, AND RECORD KEEPING RE-
19 QUIREMENTS.—The Secretary shall require each con-
20 tractor to implement (through its officers, agents, rep-
21 resentatives, and employees) requirements relating to
22 the storage and handling of covered outpatient drugs
23 and biologicals and for the establishment and mainte-
24 nance of distribution records for such drugs and
25 biologicals. A contract under this section may include
26 requirements relating to the following:

27 “(i) Secure facilities.

28 “(ii) Safe and appropriate storage of drugs
29 and biologicals.

30 “(iii) Examination of drugs and biologicals re-
31 ceived and dispensed.

32 “(iv) Disposition of damaged and outdated
33 drugs and biologicals.

34 “(v) Record keeping and written policies and
35 procedures.

36 “(vi) Compliance personnel.

1 “(E) COMPLIANCE WITH CODE OF CONDUCT AND
2 FRAUD AND ABUSE RULES.—Under the contract—

3 “(i) the contractor shall comply with a code of
4 conduct, specified or recognized by the Secretary,
5 that includes standards relating to conflicts of in-
6 terest; and

7 “(ii) the contractor will comply with all appli-
8 cable provisions relating to prevention of fraud and
9 abuse, including compliance with applicable guide-
10 lines of the Department of Justice and the Inspec-
11 tor General of the Department of Health and
12 Human Services.

13 “(F) DIRECT DELIVERY OF DRUGS AND
14 BIOLOGICALS TO PHYSICIANS.—Under the contract the
15 contractor shall only supply covered outpatient drugs
16 and biologicals directly to the selecting physicians and
17 not directly to beneficiaries, except under circumstances
18 and settings where a beneficiary currently receives a
19 drug or biological in the beneficiary’s home or other
20 non-physician office setting as the Secretary may pro-
21 vide. The contractor shall not deliver drugs and
22 biologicals to a selecting physician except upon receipt
23 of a prescription for such drugs and biologicals, and
24 such necessary data as may be required by the Sec-
25 retary to carry out this section. This section does not
26 require a physician to submit a prescription for each
27 individual treatment and does not change the physi-
28 cian’s flexibility in terms of writing a prescription for
29 drugs for a single treatment or a course of treatment.

30 “(5) PERMITTING EMERGENCY ACCESS TO DRUGS AND
31 BIOLOGICALS.—The Secretary shall establish rules under
32 this section under which drugs and biologicals which are
33 acquired through a contractor under this section may be
34 used to resupply inventories of such drugs and biologicals
35 which are administered to a patient in emergency situations
36 but only in a manner consistent with safe drug practices

1 with adequate safeguards against fraud and abuse. The
2 previous sentence shall apply in cases in which—

3 “(A) the drugs or biologicals are immediately re-
4 quired;

5 “(B) the physician could not have reasonably an-
6 ticipated the immediate requirement for the drugs or
7 biologicals; and

8 “(C) the contractor could not deliver to the physi-
9 cian the drugs or biologicals in a timely manner.

10 “(6) CONSTRUCTION.—Nothing in this section shall be
11 construed as waiving applicable State requirements relating
12 to licensing of pharmacies.

13 “(c) BIDDING PROCESS.—

14 “(1) IN GENERAL.—In awarding a contract for a cat-
15 egory of drugs and biologicals in an area under the pro-
16 gram, the Secretary shall consider with respect to each en-
17 tity seeking to be awarded a contract the prices bid to ac-
18 quire and supply the covered outpatient drugs and
19 biologicals for that category and area and the other factors
20 referred to in subsection (b)(3).

21 “(2) PRICES BID.—The prices bid by an entity under
22 paragraph (1) shall be the prices in effect and available for
23 the supply of contracted drugs and biologicals in the area
24 through the entity for the contract period.

25 “(3) REJECTION OF CONTRACT OFFER.—The Sec-
26 retary shall reject the contract offer of an entity with re-
27 spect to a category of drugs and biologicals for an area if
28 the Secretary estimates that the prices bid, in the aggre-
29 gate on average, would exceed the interim payment method-
30 ology established under subsection (f)(1).

31 “(4) BIDDING ON A NATIONAL OR REGIONAL BASIS.—
32 Nothing in this section shall be construed as precluding a
33 bidder from bidding for contracts in all areas of the United
34 States or as requiring a bidder to submit a bid for all areas
35 of the United States.

36 “(5) UNIFORMITY OF BIDS WITHIN AREA.—The
37 amount of the bid submitted under a contract offer for any

1 covered outpatient drug or biological for an area shall be
2 the same for that drug or biological for all portions of that
3 area.

4 “(6) CONFIDENTIALITY OF BIDS.—The provisions of
5 subparagraph (D) of section 1927(b)(3) shall apply to a bid
6 submitted in a contract offer for a covered outpatient drug
7 or biological under this section in the same manner as it
8 applies to information disclosed under such section, except
9 that any reference—

10 “(A) in that subparagraph to a ‘manufacturer or
11 wholesaler’ is deemed a reference to a ‘bidder’ under
12 this section;

13 “(B) in that section to ‘prices charged for drugs’
14 is deemed a reference to a ‘bid’ submitted under this
15 section; and

16 “(C) in clause (i) of that section to ‘this section’,
17 is deemed a reference to ‘part B of title XVIII’.

18 “(7) INCLUSION OF COSTS.—The bid price submitted
19 in a contract offer for a covered outpatient drug or biologi-
20 cal shall—

21 “(A) include all costs related to the delivery of the
22 drug or biological to the selecting physician (or other
23 point of delivery); and

24 “(B) include the costs of dispensing (including
25 shipping) of such drug or biological and management
26 fees, but shall not include any costs related to the ad-
27 ministration of the drug or biological, or wastage, spill-
28 age, or spoilage.

29 “(8) PRICE ADJUSTMENTS DURING CONTRACT PERIOD;
30 DISCLOSURE OF COSTS.—Each contract awarded shall pro-
31 vide for—

32 “(A) disclosure to the Secretary the contractor’s
33 reasonable, net acquisition costs for periods specified by
34 the Secretary, not more often than quarterly, of the
35 contract; and

36 “(B) appropriate price adjustments over the pe-
37 riod of the contract to reflect significant increases or

1 decreases in a contractor's reasonable, net acquisition
2 costs, as so disclosed.

3 “(d) COMPUTATION OF AVERAGE BID PRICES FOR A CAT-
4 EGORY AND AREA.—

5 “(1) IN GENERAL.—For each year or other contract
6 period for each covered outpatient drug or biological and
7 area with respect to which a competition is conducted
8 under the program, the Secretary shall compute an area
9 average of the bid prices submitted, in contract offers ac-
10 cepted for the category and area, for that year or other
11 contract period.

12 “(2) SPECIAL RULES.—The Secretary shall establish
13 rules regarding the use under this section of an alternative
14 payment amount to the use of a price for specific covered
15 outpatient drugs and biologicals in the following cases:

16 “(A) NEW DRUGS AND BIOLOGICALS.—A covered
17 outpatient drug or biological for which an average bid
18 price has not been previously determined.

19 “(B) OTHER CASES.—Such other exceptional cases
20 as the Secretary may specify in regulations.

21 Such alternative payment amount shall in no case exceed
22 the payment amount established under the interim payment
23 methodology established under subsection (f)(1) or such
24 other market price based methodology as the Secretary
25 may specify.

26 “(e) COINSURANCE.—

27 “(1) IN GENERAL.—Coinsurance under this part with
28 respect to a covered outpatient drug or biological for which
29 payment is payable under this section shall be based on 20
30 percent of the payment basis under this section.

31 “(2) COLLECTION.—Such coinsurance shall be col-
32 lected by the contractor that supplies the drug or biological
33 involved and, subject to subsection (a)(3)(B), in the same
34 manner as coinsurance is collected for durable medical
35 equipment under this part.

36 “(f) SPECIAL PAYMENT RULES.—

37 “(1) INTERIM PAYMENT METHODOLOGY.—

1 “(A) IN GENERAL.—Subject to the succeeding pro-
2 visions of this subsection, the Secretary shall establish
3 by regulation an interim payment methodology for cov-
4 ered outpatient drugs and biologicals that takes into
5 account the costs at which such drugs and biologicals
6 are reasonably available in the market, including dis-
7 counts, rebates, and chargebacks. Such payment meth-
8 odology shall be effective no later than January 1,
9 2004, except that it shall not become effective before
10 the date that adjustments to the practice expense pay-
11 ment adjustment is made on the basis of supplemental
12 surveys under section 1848(c)(2)(H)(ii) of the Social
13 Security Act, as added by subsection (a)(1)(B).

14 “(B) USE IN EXCLUSION CASES.—If the Secretary
15 excludes a drug or biological (or class of drugs or
16 biologicals) under subsection (a)(1)(D), the Secretary
17 may provide for reimbursement to be made under this
18 part for such drugs and biologicals (or class) using the
19 interim payment methodology under subparagraph (A)
20 or other market based pricing system.

21 “(C) APPLICATION WITH RESPECT TO ONCOLOGY
22 CATEGORY.—The interim payment methodology under
23 this paragraph shall not apply to a covered outpatient
24 drug or biological in the oncology category (or any sub-
25 category established by the Secretary) after December
26 31, 2004.

27 “(D) APPLICATION WITH RESPECT TO NON-ON-
28 COLOGY CATEGORY.—The interim payment method-
29 ology under this paragraph shall not apply to a covered
30 outpatient drug or biological in non-oncology categories
31 (or any subcategory established by the Secretary) after
32 December 31, 2005.

33 “(2) COORDINATION RULES.—The provisions of sec-
34 tion 1842(h)(3) shall apply to a contractor with respect to
35 covered outpatients drugs and biologicals supplied by that
36 contractor in the same manner as they apply to a partici-
37 pating supplier. In order to administer this section, the

1 Secretary may condition payment under this part to a per-
2 son for the administration of a drug or biological supplied
3 under this section upon person's provision of information
4 on such administration.

5 “(3) APPLICATION OF REQUIREMENT FOR ASSIGN-
6 MENT.—For provision requiring assignment of claims for
7 covered outpatient drugs and biologicals, see section
8 1842(o)(3).

9 “(4) PROTECTION FOR BENEFICIARY IN CASE OF MED-
10 ICAL NECESSITY DENIAL.—For protection of beneficiaries
11 against liability in the case of medical necessity determina-
12 tions, see section 1842(b)(3)(B)(ii)(III).

13 “(5) PHYSICIAN ROLE IN APPEALS PROCESS.—The
14 Secretary shall establish a procedure under which a physi-
15 cian who prescribes a drug or biological for which payment
16 is made under this section has appeal rights that are simi-
17 lar to those provided to a physician who prescribes durable
18 medical equipment or a laboratory test.

19 “(g) ADVISORY COMMITTEE.—The Secretary may estab-
20 lish an advisory committee that includes representatives of par-
21 ties affected by the program under this section, including phy-
22 sicians, specialty pharmacies, distributors, manufacturers, and
23 beneficiaries. The committee may advise the Secretary on
24 issues relating to the effective implementation of this section.

25 “(h) ANNUAL REPORTS.—The Secretary shall submit to
26 Congress an annual report in each of 2004, 2005, and 2006,
27 and every 5 years thereafter, on the program. Each such report
28 shall include information on savings, reductions in cost-sharing,
29 access to covered outpatient drugs and biologicals, the range of
30 choices of contractors available to providers, and beneficiary
31 and provider satisfaction.”.

32 (c) CONTINUATION OF PAYMENT METHODOLOGY FOR
33 RADIOPHARMACEUTICALS.—Nothing in the amendments made
34 by this section shall be construed as changing the payment
35 methodology under part B of title XVIII of the Social Security
36 Act for radiopharmaceuticals, including the use by carriers of
37 invoice pricing methodology.

1 (d) CONFORMING AMENDMENTS.—

2 (1) IN GENERAL.—Section 1842(o) (42 U.S.C.
3 1395u(o)) is amended—

4 (A) in paragraph (1), by inserting “, subject to
5 section 1847A,” before “the amount payable for the
6 drug or biological”; and

7 (B) by adding at the end of paragraph (2) the fol-
8 lowing: “This paragraph shall not apply in the case of
9 payment under section 1847A.”.

10 (2) NO CHANGE IN COVERAGE BASIS.—Section
11 1861(s)(2)(A) (42 U.S.C. 1395x(s)(2)(A)) is amended by
12 inserting “(or would have been so included but for the ap-
13 plication of section 1847A)” after “included in the physi-
14 cians’ bills”.

15 (3) PAYMENT.—Section 1833(a)(1)(S) (42 U.S.C.
16 1395l(a)(1)(S)) is amended by inserting “(or, if applicable,
17 under section 1847A)” after “1842(o)”.

18 (e) GAO STUDY.—

19 (1) STUDY.—The Comptroller General of the United
20 States shall conduct a study to assess the impact of the
21 amendments made by this section on the delivery of serv-
22 ices, including their impact on—

23 (A) beneficiary access to drugs and biologicals for
24 which payment is made under part B of title XVIII of
25 the Social Security Act; and

26 (B) the site of delivery of such services.

27 (2) REPORT.—Not later than 2 years after the year in
28 which the amendment made by subsection (a)(1) first takes
29 effect, the Comptroller General shall submit to Congress a
30 report on the study conducted under paragraph (1).

31 (f) MEDPAC RECOMMENDATIONS ON BLOOD CLOTTING
32 FACTORS.—The Medicare Payment Advisory Commission shall
33 submit to Congress, in its annual report in 2004, specific rec-
34 ommendations regarding a payment amount (or amounts) for
35 blood clotting factors and its administration under the medi-
36 care program.

SEC. 304. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the “project”) to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the medicare program for services for which payment is made under part A or part B of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—

(1) SCOPE.—The project shall cover at least 2 States that are among the States with—

(A) the highest per capita utilization rates of medicare services, and

(B) at least 3 contractors.

(2) DURATION.—The project shall last for not longer than 3 years.

(c) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical

1 knowledge of and experience with the payment rules and
2 regulations under the medicare program or the entity has
3 or will contract with another entity that has such knowl-
4 edgeable and experienced staff.

5 (2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The
6 Secretary may not enter into a recovery audit contract
7 under this section with an entity to the extent that the en-
8 tity is a fiscal intermediary under section 1816 of the So-
9 cial Security Act (42 U.S.C. 1395h), a carrier under sec-
10 tion 1842 of such Act (42 U.S.C. 1395u), or a Medicare
11 Administrative Contractor under section 1874A of such
12 Act.

13 (3) PREFERENCE FOR ENTITIES WITH DEM-
14 ONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—In
15 awarding contracts to recovery audit contractors under this
16 section, the Secretary shall give preference to those risk en-
17 tities that the Secretary determines have demonstrated
18 more than 3 years direct management experience and a
19 proficiency in recovery audits with private insurers or
20 under the medicaid program under title XIX of such Act.

21 (e) CONSTRUCTION RELATING TO CONDUCT OF INVES-
22 TIGATION OF FRAUD.—A recovery of an overpayment to a pro-
23 vider by a recovery audit contractor shall not be construed to
24 prohibit the Secretary or the Attorney General from inves-
25 tigating and prosecuting, if appropriate, allegations of fraud or
26 abuse arising from such overpayment.

27 (f) REPORT.—The Secretary of Health and Human Serv-
28 ices shall submit to Congress a report on the project not later
29 than 6 months after the date of its completion. Such reports
30 shall include information on the impact of the project on sav-
31 ings to the medicare program and recommendations on the
32 cost-effectiveness of extending or expanding the project.

**TITLE IV—RURAL HEALTH CARE
IMPROVEMENTS**

SEC. 401. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) DOUBLING THE CAP.—

(1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

“(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2003, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

“(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 10 percent for a hospital that is not classified as a rural referral center under subparagraph (C).”.

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting “subject to clause (xiv) and” before “for discharges occurring”;

(B) in clause (viii), by striking “The formula” and inserting “Subject to clause (xiv), the formula”; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking “For purposes” and inserting “Subject to clause (xiv), for purposes”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to discharges occurring on or after October 1, 2003.

**SEC. 402. IMMEDIATE ESTABLISHMENT OF UNIFORM
STANDARDIZED AMOUNT IN RURAL AND
SMALL URBAN AREAS.**

(a) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended—

(1) in clause (iv), by inserting “and ending on or before September 30, 2003,” after “October 1, 1995,”; and

(2) by redesignating clauses (v) and (vi) as clauses (vii) and (viii), respectively, and inserting after clause (iv) the following new clauses:

“(v) For discharges occurring in the fiscal year beginning on October 1, 2003, the average standardized amount for hospitals located in areas other than a large urban area shall be equal to the average standardized amount for hospitals located in a large urban area.”.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking “IN DIFFERENT AREAS”;

(B) in the matter preceding clause (i), by striking “, each of”;

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2004,” before “for hospitals”; and

(ii) in subclause (II), by striking “and” after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2004,” before “for hospitals”; and

(ii) in subclause (II), by striking the period at the end and inserting “; and”; and

(E) by adding at the end the following new clause:

“(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

“(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

“(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.”.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting “, for fiscal years before fiscal year 1997,” before “a regional adjusted DRG prospective payment rate”; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting “, for fiscal years before fiscal year 1997,” before “a regional DRG prospective payment rate for each region,”.

SEC. 403. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL CLASSIFICATION.

(a) CLASSIFICATION.—Section 1861(mm) (42 U.S.C. 1395x(mm)) is amended—

(1) in the heading by adding “ESSENTIAL RURAL HOSPITALS” at the end; and

(2) by adding at the end the following new paragraphs:

“(4)(A) The term ‘essential rural hospital’ means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is located in a rural area (as defined for purposes of section 1886(d)), has more than 25 licensed acute care inpatient beds, has applied to the Secretary for classification as such a hospital, and with respect to which the Secretary has determined that the closure of the hospital would significantly diminish the ability of medicare beneficiaries to obtain essential health care services.

1 “(B) The determination under subparagraph (A) shall be
2 based on the following criteria:

3 “(i) HIGH PROPORTION OF MEDICARE BENEFICIARIES
4 RECEIVING CARE FROM HOSPITAL.—(I) A high percentage
5 of such beneficiaries residing in the area of the hospital
6 who are hospitalized (during the most recent year for which
7 complete data are available) receive basic inpatient medical
8 care at the hospital.

9 “(II) For a hospital with more than 200 licensed beds,
10 a high percentage of such beneficiaries residing in such
11 area who are hospitalized (during such recent year) receive
12 specialized surgical inpatient care at the hospital.

13 “(III) Almost all physicians described in section
14 1861(r)(1) in such area have privileges at the hospital and
15 provide their inpatient services primarily at the hospital.

16 “(ii) SIGNIFICANT ADVERSE IMPACT IN ABSENCE OF
17 HOSPITAL.—If the hospital were to close—

18 “(I) there would be a significant amount of time
19 needed for residents to reach emergency treatment, re-
20 sulting in a potential significant harm to beneficiaries
21 with critical illnesses or injuries;

22 “(II) there would be an inability in the community
23 to stabilize emergency cases for transfers to another
24 acute care setting, resulting in a potential for signifi-
25 cant harm to medicare beneficiaries; and

26 “(III) any other nearby hospital lacks the physical
27 and clinical capacity to take over the hospital’s typical
28 admissions.

29 “(C) In making such determination, the Secretary may
30 also consider the following:

31 “(i) Free-standing ambulatory surgery centers, office-
32 based oncology care, and imaging center services are insuf-
33 ficient in the hospital’s area to handle the outpatient care
34 of the hospital.

35 “(ii) Beneficiaries in nearby areas would be adversely
36 affected if the hospital were to close as the hospital pro-

1 vides specialized knowledge and services to a network of
2 smaller hospitals and critical access hospitals.

3 “(iii) Medicare beneficiaries would have difficulty in
4 accessing care if the hospital were to close as the hospital
5 provides significant subsidies to support ambulatory care in
6 local clinics, including mental health clinics and to support
7 post acute care.

8 “(iv) The hospital has a committment to provide grad-
9 uate medical education in a rural area.

10 “(C) QUALITY CARE.—The hospital inpatient score for
11 quality of care is not less than the median hospital score
12 for qualify of care for hospitals in the State, as established
13 under standards of the utilization and quality control peer
14 review organization under part B of title XI or other qual-
15 ity standards recognized by the Secretary.

16 A hospital classified as an essential rural hospital may not
17 change such classification and a hospital so classified shall not
18 be treated as a sole community hospital, medicare dependent
19 hospital, or rural referral center for purposes of section 1886.”.

20 (b) PAYMENT BASED ON 102 PERCENT OF ALLOWED
21 COSTS.—

22 (1) INPATIENT HOSPITAL SERVICES.—Section 1886(d)
23 (42 U.S.C. 1395ww(d)) is amended by adding at the end
24 the following:

25 “(11) In the case of a hospital classified as an essential
26 rural hospital under section 1861(mm)(4) for a cost reporting
27 period, the payment under this subsection for inpatient hospital
28 services for discharges occurring during the period shall be
29 based on 102 percent of the reasonable costs for such services.
30 Nothing in this paragraph shall be construed as affecting the
31 application or amount of deductibles or copayments otherwise
32 applicable to such services under part A or as waiving any re-
33 quirement for billing for such services.”.

34 (2) HOSPITAL OUTPATIENT SERVICES.—Section
35 1833(t)(13) (42 U.S.C. 1395l(t)(13)) is amended by add-
36 ing at the end the following new subparagraph:

1 “(B) SPECIAL RULE FOR ESSENTIAL RURAL HOS-
2 PITALS.—In the case of a hospital classified as an es-
3 sential rural hospital under section 1861(mm)(4) for a
4 cost reporting period, the payment under this sub-
5 section for covered OPD services during the period
6 shall be based on 102 percent of the reasonable costs
7 for such services. Nothing in this subparagraph shall be
8 construed as affecting the application or amount of
9 deductibles or copayments otherwise applicable to such
10 services under this part or as waiving any requirement
11 for billing for such services.”.

12 (c) EFFECTIVE DATE.—The amendments made by this
13 section shall apply to cost reporting periods beginning on or
14 after October 1, 2004.

15 **SEC. 404. MORE FREQUENT UPDATE IN WEIGHTS USED**
16 **IN HOSPITAL MARKET BASKET.**

17 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After re-
18 vising the weights used in the hospital market basket under
19 section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C.
20 1395ww(b)(3)(B)(iii)) to reflect the most current data avail-
21 able, the Secretary shall establish a frequency for revising such
22 weights, including the labor share, in such market basket to re-
23 flect the most current data available more frequently than once
24 every 5 years.

25 (b) REPORT.—Not later than October 1, 2004, the Sec-
26 retary shall submit a report to Congress on the frequency es-
27 tablished under subsection (a), including an explanation of the
28 reasons for, and options considered, in determining such fre-
29 quency.

30 **SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOS-**
31 **PITAL PROGRAM.**

32 (a) INCREASE IN PAYMENT AMOUNTS.—

33 (1) IN GENERAL.—Sections 1814(l), 1834(g)(1), and
34 1883(a)(3) (42 U.S.C. 1395f(l); 1395m(g)(1); 42 U.S.C.
35 1395tt(a)(3)) are each amended by inserting “equal to 102
36 percent of” before “the reasonable costs”.

1 (2) EFFECTIVE DATE.—The amendments made by
2 paragraph (1) shall apply to payments for services fur-
3 nished during cost reporting periods beginning on or after
4 October 1, 2003.

5 (b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY
6 ROOM ON-CALL PROVIDERS.—

7 (1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C.
8 1395m(g)(5)) is amended—

9 (A) in the heading—

10 (i) by inserting “CERTAIN” before “EMER-
11 GENCY”; and

12 (ii) by striking “PHYSICIANS” and inserting
13 “PROVIDERS”;

14 (B) by striking “emergency room physicians who
15 are on-call (as defined by the Secretary)” and inserting
16 “physicians, physician assistants, nurse practitioners,
17 and clinical nurse specialists who are on-call (as de-
18 fined by the Secretary) to provide emergency services”;
19 and

20 (C) by striking “physicians’ services” and insert-
21 ing “services covered under this title”.

22 (2) EFFECTIVE DATE.—The amendment made by
23 paragraph (1) shall apply with respect to costs incurred for
24 services provided on or after January 1, 2004.

25 (c) MODIFICATION OF THE ISOLATION TEST FOR COST-
26 BASED CAH AMBULANCE SERVICES.—

27 (1) IN GENERAL.—Section 1834(l)(8) (42 U.S.C.
28 1395m(l)), as added by section 205(a) of BIPA (114 Stat.
29 2763A–482), is amended by adding at the end the fol-
30 lowing: “The limitation described in the matter following
31 subparagraph (B) in the previous sentence shall not apply
32 if the ambulance services are furnished by such a provider
33 or supplier of ambulance services who is a first responder
34 to emergencies (as determined by the Secretary).”.

35 (2) EFFECTIVE DATE.—The amendment made by
36 paragraph (1) shall apply to ambulances services furnished

1 on or after the first cost reporting period that begins after
2 the date of the enactment of this Act.

3 (d) REINSTATEMENT OF PERIODIC INTERIM PAYMENT
4 (PIP).—

5 (1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C.
6 1395g(e)(2)) is amended—

7 (A) in the matter before subparagraph (A), by in-
8 serting “, in the cases described in subparagraphs (A)
9 through (D)” after “1986”; and

10 (B) by striking “and” at the end of subparagraph
11 (C);

12 (C) by adding “and” at the end of subparagraph
13 (D); and

14 (D) by inserting after subparagraph (D) the fol-
15 lowing new subparagraph:

16 “(E) inpatient critical access hospital services;”.

17 (2) DEVELOPMENT OF ALTERNATIVE METHODS OF
18 PERIODIC INTERIM PAYMENTS.—With respect to periodic
19 interim payments to critical access hospitals for inpatient
20 critical access hospital services under section 1815(e)(2)(E)
21 of the Social Security Act, as added by paragraph (1), the
22 Secretary shall develop alternative methods for such pay-
23 ments that are based on expenditures of the hospital.

24 (3) REINSTATEMENT OF PIP.—The amendments made
25 by paragraph (1) shall apply to payments made on or after
26 January 1, 2004.

27 (e) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN
28 PAYMENT ADJUSTMENT.—

29 (1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C.
30 1395m(g)(2)) is amended by adding after and below sub-
31 paragraph (B) the following:

32 “The Secretary may not require, as a condition for apply-
33 ing subparagraph (B) with respect to a critical access hos-
34 pital, that each physician providing professional services in
35 the hospital must assign billing rights with respect to such
36 services, except that such subparagraph shall not apply to

1 those physicians who have not assigned such billing
2 rights.”.

3 (2) EFFECTIVE DATE.—The amendment made by
4 paragraph (1) shall be effective as if included in the enact-
5 ment of section 403(d) of the Medicare, Medicaid, and
6 SCHIP Balanced Budget Refinement Act of 1999 (113
7 Stat. 1501A–371).

8 (f) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS.—
9 Section 1820 (42 U.S.C. 1395i–4) is amended—

10 (1) in subsection (c)(2)(B)(iii), by inserting “subject
11 to paragraph (3)” after “(iii) provides”;

12 (2) by adding at the end of subsection (c) the fol-
13 lowing new paragraph:

14 “(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR
15 HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUA-
16 TIONS.—

17 “(A) IN GENERAL.—Subject to subparagraph (C),
18 in the case of a hospital that demonstrates that it
19 meets the standards established under subparagraph
20 (B) and has not made the election described in sub-
21 section (f)(2)(A), the bed limitations otherwise applica-
22 ble under paragraph (2)(B)(iii) and subsection (f) shall
23 be increased by 5 beds.

24 “(B) STANDARDS.—The Secretary shall specify
25 standards for determining whether a critical access hos-
26 pital has sufficiently strong seasonal variations in pa-
27 tient admissions to justify the increase in bed limitation
28 provided under subparagraph (A).”; and

29 (3) in subsection (f)—

30 (A) by inserting “(1)” after “(f)”; and

31 (B) by adding at the end the following new para-
32 graph:

33 “(2)(A) A hospital may elect to treat the reference in
34 paragraph (1) to ‘15 beds’ as a reference to ‘25 beds’, but only
35 if no more than 10 beds in the hospital are at any time used
36 for non-acute care services. A hospital that makes such an elec-

1 tion is not eligible for the increase provided under subsection
2 (c)(3)(A).

3 “(B) The limitations in numbers of beds under the first
4 sentence of paragraph (1) are subject to adjustment under sub-
5 section (c)(3).”.

6 (4) EFFECTIVE DATE.—The amendments made by
7 this subsection shall apply to designations made before, on,
8 or after January 1, 2004.

9 (g) ADDITIONAL 5-YEAR PERIOD OF FUNDING FOR
10 GRANT PROGRAM.—

11 (1) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i-
12 4(g)) is amended by adding at the end the following new
13 paragraph:

14 “(4) FUNDING.—

15 “(A) IN GENERAL.—Subject to subparagraph (B),
16 payment for grants made under this subsection during
17 fiscal years 2004 through 2008 shall be made from the
18 Federal Hospital Insurance Trust Fund.

19 “(B) ANNUAL AGGREGATE LIMITATION.—In no
20 case may the amount of payment provided for under
21 subparagraph (A) for a fiscal year exceed
22 \$25,000,000.”.

23 (2) CONFORMING AMENDMENT.—Section 1820 (42
24 U.S.C. 1395i-4) is amended by striking subsection (j).

25 **SEC. 406. REDISTRIBUTION OF UNUSED RESIDENT POSI-**
26 **TIONS.**

27 (a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C.
28 1395ww(h)(4)) is amended—

29 (1) in subparagraph (F)(i), by inserting “subject to
30 subparagraph (I),” after “October 1, 1997,”;

31 (2) in subparagraph (H)(i), by inserting “subject to
32 subparagraph (I),” after “subparagraphs (F) and (G),”;
33 and

34 (3) by adding at the end the following new subpara-
35 graph:

36 “(I) REDISTRIBUTION OF UNUSED RESIDENT PO-
37 SITIONS.—

1 “(i) REDUCTION IN LIMIT BASED ON UNUSED
2 POSITIONS.—

3 “(I) IN GENERAL.—If a hospital’s resident
4 level (as defined in clause (iii)(I)) is less than
5 the otherwise applicable resident limit (as de-
6 fined in clause (iii)(II)) for each of the ref-
7 erence periods (as defined in subclause (II)),
8 effective for cost reporting periods beginning on
9 or after January 1, 2004, the otherwise appli-
10 cable resident limit shall be reduced by 75 per-
11 cent of the difference between such limit and
12 the reference resident level specified in sub-
13 clause (III) (or subclause (IV) if applicable).

14 “(II) REFERENCE PERIODS DEFINED.—In
15 this clause, the term ‘reference periods’ means,
16 for a hospital, the 3 most recent consecutive
17 cost reporting periods of the hospital for which
18 cost reports have been settled (or, if not, sub-
19 mitted) on or before September 30, 2002.

20 “(III) REFERENCE RESIDENT LEVEL.—
21 Subject to subclause (IV), the reference resi-
22 dent level specified in this subclause for a hos-
23 pital is the highest resident level for the hos-
24 pital during any of the reference periods.

25 “(IV) ADJUSTMENT PROCESS.—Upon the
26 timely request of a hospital, the Secretary may
27 adjust the reference resident level for a hospital
28 to be the resident level for the hospital for the
29 cost reporting period that includes July 1,
30 2003.

31 “(V) AFFILIATION.—With respect to hos-
32 pitals which are members of the same affiliated
33 group (as defined by the Secretary under sub-
34 paragraph (H)(ii)), the provisions of this sec-
35 tion shall be applied with respect to such an af-
36 filiated group by deeming the affiliated group
37 to be a single hospital.

1 “(ii) REDISTRIBUTION.—

2 “(I) IN GENERAL.—The Secretary is au-
3 thorized to increase the otherwise applicable
4 resident limits for hospitals by an aggregate
5 number estimated by the Secretary that does
6 not exceed the aggregate reduction in such lim-
7 its attributable to clause (i) (without taking
8 into account any adjustment under subclause
9 (IV) of such clause).

10 “(II) EFFECTIVE DATE.—No increase
11 under subclause (I) shall be permitted or taken
12 into account for a hospital for any portion of
13 a cost reporting period that occurs before July
14 1, 2004, or before the date of the hospital’s ap-
15 plication for an increase under this clause. No
16 such increase shall be permitted for a hospital
17 unless the hospital has applied to the Secretary
18 for such increase by December 31, 2005.

19 “(III) CONSIDERATIONS IN REDISTRIBU-
20 TION.—In determining for which hospitals the
21 increase in the otherwise applicable resident
22 limit is provided under subclause (I), the Sec-
23 retary shall take into account the need for such
24 an increase by specialty and location involved,
25 consistent with subclause (IV).

26 “(IV) PRIORITY FOR RURAL AND SMALL
27 URBAN AREAS.—In determining for which hos-
28 pitals and residency training programs an in-
29 crease in the otherwise applicable resident limit
30 is provided under subclause (I), the Secretary
31 shall first distribute the increase to programs
32 of hospitals located in rural areas or in urban
33 areas that are not large urban areas (as de-
34 fined for purposes of subsection (d)) on a first-
35 come-first-served basis (as determined by the
36 Secretary) based on a demonstration that the
37 hospital will fill the positions made available

1 under this clause and not to exceed an increase
2 of 25 full-time equivalent positions with respect
3 to any hospital.

4 “(V) APPLICATION OF LOCALITY AD-
5 JUSTED NATIONAL AVERAGE PER RESIDENT
6 AMOUNT.—With respect to additional residency
7 positions in a hospital attributable to the in-
8 crease provided under this clause, notwith-
9 standing any other provision of this subsection,
10 the approved FTE resident amount is deemed
11 to be equal to the locality adjusted national av-
12 erage per resident amount computed under
13 subparagraph (E) for that hospital.

14 “(VI) CONSTRUCTION.—Nothing in this
15 clause shall be construed as permitting the re-
16 distribution of reductions in residency positions
17 attributable to voluntary reduction programs
18 under paragraph (6) or as affecting the ability
19 of a hospital to establish new medical residency
20 training programs under subparagraph (H).

21 “(iii) RESIDENT LEVEL AND LIMIT DE-
22 FINED.—In this subparagraph:

23 “(I) RESIDENT LEVEL.—The term ‘resi-
24 dent level’ means, with respect to a hospital,
25 the total number of full-time equivalent resi-
26 dents, before the application of weighting fac-
27 tors (as determined under this paragraph), in
28 the fields of allopathic and osteopathic medi-
29 cine for the hospital.

30 “(II) OTHERWISE APPLICABLE RESIDENT
31 LIMIT.—The term ‘otherwise applicable resi-
32 dent limit’ means, with respect to a hospital,
33 the limit otherwise applicable under subpara-
34 graphs (F)(i) and (H) on the resident level for
35 the hospital determined without regard to this
36 subparagraph.”.

1 (b) CONFORMING AMENDMENT TO IME.—Section
2 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended
3 by adding at the end the following: “The provisions of subpara-
4 graph (I) of subsection (h)(4) shall apply with respect to the
5 first sentence of this clause in the same manner as it applies
6 with respect to subparagraph (F) of such subsection.”.

7 (c) REPORT ON EXTENSION OF APPLICATIONS UNDER
8 REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the
9 Secretary shall submit to Congress a report containing rec-
10 ommendations regarding whether to extend the deadline for ap-
11 plications for an increase in resident limits under section
12 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by
13 subsection (a)).

14 **SEC. 407. TWO-YEAR EXTENSION OF HOLD HARMLESS**
15 **PROVISIONS FOR SMALL RURAL HOSPITALS**
16 **AND SOLE COMMUNITY HOSPITALS UNDER**
17 **PROSPECTIVE PAYMENT SYSTEM FOR HOS-**
18 **PITAL OUTPATIENT DEPARTMENT SERV-**
19 **ICES.**

20 (a) HOLD HARMLESS PROVISIONS.—

21 (1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42
22 U.S.C. 1395l(t)(7)(D)(i)) is amended—

23 (A) in the heading, by striking “SMALL” and in-
24 serting “CERTAIN”;

25 (B) by inserting “or a sole community hospital (as
26 defined in section 1886(d)(5)(D)(iii)) located in a rural
27 area” after “100 beds”; and

28 (C) by striking “2004” and inserting “2006”.

29 (2) EFFECTIVE DATE.—The amendment made by sub-
30 section (a)(2) shall apply with respect to payment for OPD
31 services furnished on and after January 1, 2004.

32 (b) STUDY; ADJUSTMENT.—

33 (1) STUDY.—The Secretary shall conduct a study to
34 determine if, under the prospective payment system for
35 hospital outpatient department services under section
36 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)),
37 costs incurred by rural providers of services by ambulatory

1 payment classification groups (APCs) exceed those costs in-
2 curred by urban providers of services.

3 (2) ADJUSTMENT.—Insofar as the Secretary deter-
4 mines under paragraph (1) that costs incurred by rural
5 providers exceed those costs incurred by urban providers of
6 services, the Secretary shall provide for an appropriate ad-
7 justment under such section 1833(t) to reflect those higher
8 costs by January 1, 2005.

9 **SEC. 408. EXCLUSION OF CERTAIN RURAL HEALTH CLIN-**
10 **IC AND FEDERALLY QUALIFIED HEALTH**
11 **CENTER SERVICES FROM THE PROSPECTIVE**
12 **PAYMENT SYSTEM FOR SKILLED NURSING**
13 **FACILITIES.**

14 (a) IN GENERAL.—Section 1888(e)(2)(A) (42 U.S.C.
15 1395yy(e)(2)(A)) is amended—

16 (1) in clause (i)(II), by striking “clauses (ii) and (iii)”
17 and inserting “clauses (ii), (iii), and (iv)”;

18 (2) by adding at the end the following new clause:

19 “(iv) EXCLUSION OF CERTAIN RURAL HEALTH
20 CLINIC AND FEDERALLY QUALIFIED HEALTH CEN-
21 TER SERVICES.—Services described in this clause
22 are—

23 “(I) rural health clinic services (as defined
24 in paragraph (1) of section 1861(aa)); and

25 “(II) Federally qualified health center
26 services (as defined in paragraph (3) of such
27 section);

28 that would be described in clause (ii) if such serv-
29 ices were not furnished by an individual affiliated
30 with a rural health clinic or a Federally qualified
31 health center.”.

32 (b) EFFECTIVE DATE.—The amendments made by sub-
33 section (a) shall apply to services furnished on or after January
34 1, 2004.

1 **SEC. 409. RECOGNITION OF ATTENDING NURSE PRACTI-**
2 **TIONERS AS ATTENDING PHYSICIANS TO**
3 **SERVE HOSPICE PATIENTS.**

4 (a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C.
5 1395x(dd)(3)(B)) is amended by inserting “or nurse practi-
6 tioner (as defined in subsection (aa)(5))” after “the physician
7 (as defined in subsection (r)(1))”.

8 (b) PROHIBITION ON NURSE PRACTITIONER CERTIFYING
9 NEED FOR HOSPICE.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C.
10 1395f(a)(7)(A)(i)(I)) is amended by inserting “(which for pur-
11 poses of this subparagraph does not include a nurse practi-
12 tioner)” after “attending physician (as defined in section
13 1861(dd)(3)(B))”.

14 **SEC. 410. IMPROVEMENT IN PAYMENTS TO RETAIN**
15 **EMERGENCY CAPACITY FOR AMBULANCE**
16 **SERVICES IN RURAL AREAS.**

17 Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

18 (1) by redesignating paragraph (8), as added by sec-
19 tion 221(a) of BIPA (114 Stat. 2763A–486), as paragraph
20 (9); and

21 (2) by adding at the end the following new paragraph:

22 “(10) ASSISTANCE FOR RURAL PROVIDERS
23 FURNISHING SERVICES IN LOW MEDICARE POPULATION
24 DENSITY AREAS.—

25 “(A) IN GENERAL.—In the case of ground ambu-
26 lance services furnished on or after January 1, 2004,
27 for which the transportation originates in a qualified
28 rural area (as defined in subparagraph (B)), the Sec-
29 retary shall provide for an increase in the base rate of
30 the fee schedule for mileage for a trip established under
31 this subsection that the Secretary estimates, taking
32 into account the higher average costs incurred by pro-
33 viders furnishing a low volume of ambulance services.
34 The Secretary may provide for a greater increase for
35 providers in frontier areas based on the Secretary’s
36 findings of even higher average costs incurred because
37 of even lower volume of ambulance services furnished
38 in such an area.

“(B) QUALIFIED RURAL AREA DEFINED.—For purposes of subparagraph (A), the term ‘qualified rural area’ is—

“(i) a rural area (as defined in section 1886(d)(2)(D)); or

“(ii) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), with a population density of medicare beneficiaries residing in the area that is in the lowest three quartiles of all rural county populations.”.

SEC. 411. ONE-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) during fiscal year 2004, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

SEC. 412. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a-7(b)(3)), as amended by section 101(b)(2), is amended—

(1) in subparagraph (F), by striking “and” after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting “; and”; and

1 (3) by adding at the end the following new subpara-
2 graph:

3 “(H) any remuneration between a public or non-
4 profit private health center entity described under
5 clause (i) or (ii) of section 1905(l)(2)(B) and any indi-
6 vidual or entity providing goods, items, services, dona-
7 tions or loans, or a combination thereof, to such health
8 center entity pursuant to a contract, lease, grant, loan,
9 or other agreement, if such agreement contributes to
10 the ability of the health center entity to maintain or in-
11 crease the availability, or enhance the quality, of serv-
12 ices provided to a medically underserved population
13 served by the health center entity.”.

14 (b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER
15 ENTITY ARRANGEMENTS.—

16 (1) ESTABLISHMENT.—

17 (A) IN GENERAL.—The Secretary of Health and
18 Human Services (in this subsection referred to as the
19 “Secretary”) shall establish, on an expedited basis,
20 standards relating to the exception described in section
21 1128B(b)(3)(H) of the Social Security Act, as added
22 by subsection (a), for health center entity arrangements
23 to the antikickback penalties.

24 (B) FACTORS TO CONSIDER.—The Secretary shall
25 consider the following factors, among others, in estab-
26 lishing standards relating to the exception for health
27 center entity arrangements under subparagraph (A):

28 (i) Whether the arrangement between the
29 health center entity and the other party results in
30 savings of Federal grant funds or increased reve-
31 nues to the health center entity.

32 (ii) Whether the arrangement between the
33 health center entity and the other party restricts or
34 limits a patient’s freedom of choice.

35 (iii) Whether the arrangement between the
36 health center entity and the other party protects a
37 health care professional’s independent medical

1 judgment regarding medically appropriate treat-
2 ment.

3 The Secretary may also include other standards and
4 criteria that are consistent with the intent of Congress
5 in enacting the exception established under this section.

6 (2) INTERIM FINAL EFFECT.—No later than 180 days
7 after the date of enactment of this Act, the Secretary shall
8 publish a rule in the Federal Register consistent with the
9 factors under paragraph (1)(B). Such rule shall be effective
10 and final immediately on an interim basis, subject to such
11 change and revision, after public notice and opportunity
12 (for a period of not more than 60 days) for public com-
13 ment, as is consistent with this subsection.

14 **SEC. 413. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN**
15 **PAYMENTS FOR PHYSICIANS' SERVICES.**

16 (a) STUDY.—The Comptroller General of the United
17 States shall conduct a study of differences in payment amounts
18 under the physician fee schedule under section 1848 of the So-
19 cial Security Act (42 U.S.C. 1395w-4) for physicians' services
20 in different geographic areas. Such study shall include—

21 (1) an assessment of the validity of the geographic ad-
22 justment factors used for each component of the fee sched-
23 ule;

24 (2) an evaluation of the measures used for such ad-
25 justment, including the frequency of revisions; and

26 (3) an evaluation of the methods used to determine
27 professional liability insurance costs used in computing the
28 malpractice component, including a review of increases in
29 professional liability insurance premiums and variation in
30 such increases by State and physician specialty and meth-
31 ods used to update the geographic cost of practice index
32 and relative weights for the malpractice component.

33 (b) REPORT.—Not later than 1 year after the date of the
34 enactment of this Act, the Comptroller General shall submit to
35 Congress a report on the study conducted under subsection (a).
36 The report shall include recommendations regarding the use of
37 more current data in computing geographic cost of practice in-

1 dices as well as the use of data directly representative of physi-
2 cians' costs (rather than proxy measures of such costs).

3 **SEC. 414. TREATMENT OF MISSING COST REPORTING**
4 **PERIODS FOR SOLE COMMUNITY HOS-**
5 **PITALS.**

6 (a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C.
7 1395ww(b)(3)(I)) is amended by adding at the end the fol-
8 lowing new clause:

9 “(iii) In no case shall a hospital be denied treatment as
10 a sole community hospital or payment (on the basis of a target
11 rate as such as a hospital) because data are unavailable for any
12 cost reporting period due to changes in ownership, changes in
13 fiscal intermediaries, or other extraordinary circumstances, so
14 long as data for at least one applicable base cost reporting pe-
15 riod is available.”.

16 (b) EFFECTIVE DATE.—The amendment made by sub-
17 section (a) shall apply to cost reporting periods beginning on
18 or after January 1, 2004.

19 **TITLE V—PROVISIONS RELATING**
20 **TO PART A**
21 **Subtitle A—Inpatient Hospital**
22 **Services**

23 **SEC. 501. REVISION OF ACUTE CARE HOSPITAL PAY-**
24 **MENT UPDATES.**

25 Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i))
26 is amended—

- 27 (1) by striking “and” at the end of subclause (XVIII);
28 (2) by striking subclause (XIX); and
29 (3) by inserting after subclause (XVIII) the following
30 new subclauses:

31 “(XIX) for each of fiscal years 2004 through 2006,
32 the market basket percentage increase minus 0.4 percent-
33 age points for hospitals in all areas; and

34 “(XX) for fiscal year 2007 and each subsequent fiscal
35 year, the market basket percentage increase for hospitals in
36 all areas.”.

SEC. 502. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

“(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.”.

(b) ELIGIBILITY STANDARD FOR TECHNOLOGY OUTLIERS.—

(1) MINIMUM PERIOD FOR RECOGNITION OF NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

(A) by inserting “(I)” after “(vi)”; and

(B) by adding at the end the following new subclause:

“(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of specific discharges in which the service or technology has been used.”.

(2) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting “(applying a threshold specified by the Secretary that is 75 percent of one standard deviation for the diagnosis-related group involved)” after “is inadequate”.

(3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is

1 further amended by adding at the end the following sub-
2 clause:

3 “(III) The Secretary shall by regulation provide for fur-
4 ther clarification of the criteria applied to determine whether
5 a new service or technology represents an advance in medical
6 technology that substantially improves the diagnosis or treat-
7 ment of beneficiaries. Under such criteria, in determining
8 whether a new service or technology represents an advance in
9 medical technology that substantially improves the diagnosis or
10 treatment of beneficiaries, the Secretary shall deem a service
11 or technology as meeting such requirement if the service or
12 technology is a drug or biological that is designated under sec-
13 tion 506 of the Federal Food, Drug, and Cosmetic Act, ap-
14 proved under section 314.510 or 601.41 of title 21, Code of
15 Federal Regulations, or designated for priority review when the
16 marketing application for such drug or biological was filed or
17 is a medical device for which an exemption has been granted
18 under section 520(m) of such Act, or for which priority review
19 has been provided under section 515(d)(5) of such Act. Noth-
20 ing in this subclause shall be construed as effecting the author-
21 ity of the Secretary to determine whether items and services
22 are medically necessary and appropriate under section
23 1862(a)(1).”.

24 (4) PROCESS FOR PUBLIC INPUT.—Section
25 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended
26 by paragraph (1), is amended—

27 (A) in clause (i), by adding at the end the fol-
28 lowing: “Such mechanism shall be modified to meet the
29 requirements of clause (viii).”; and

30 (B) by adding at the end the following new clause:

31 “(viii) The mechanism established pursuant to clause (i)
32 shall be adjusted to provide, before publication of a proposed
33 rule, for public input regarding whether a new service or tech-
34 nology not described in the second sentence of clause (vi)(III)
35 represents an advance in medical technology that substantially
36 improves the diagnosis or treatment of beneficiaries as follows:

1 “(I) The Secretary shall make public and periodically
2 update a list of all the services and technologies for which
3 an application for additional payment under this subpara-
4 graph is pending.

5 “(II) The Secretary shall accept comments, rec-
6 ommendations, and data from the public regarding whether
7 the service or technology represents a substantial improve-
8 ment.

9 “(III) The Secretary shall provide for a meeting at
10 which organizations representing hospitals, physicians,
11 medicare beneficiaries, manufacturers, and any other inter-
12 ested party may present comments, recommendations, and
13 data to the clinical staff of the Centers for Medicare &
14 Medicaid Services before publication of a notice of proposed
15 rulemaking regarding whether service or technology rep-
16 resents a substantial improvement.”.

17 (c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Sec-
18 tion 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further
19 amended by adding at the end the following new clause:

20 “(ix) Before establishing any add-on payment under this
21 subparagraph with respect to a new technology, the Secretary
22 shall seek to identify one or more diagnosis-related groups as-
23 sociated with such technology, based on similar clinical or ana-
24 tomical characteristics and the cost of the technology. Within
25 such groups the Secretary shall assign an eligible new tech-
26 nology into a diagnosis-related group where the average costs
27 of care most closely approximate the costs of care of using the
28 new technology. In such case, the new technology would no
29 longer meet the threshold of exceeding 75 percent of the stand-
30 ard deviation for the diagnosis-related group involved under
31 clause (ii)(I). No add-on payment under this subparagraph
32 shall be made with respect to such new technology and this
33 clause shall not affect the application of paragraph
34 (4)(C)(iii).”.

35 (d) IMPROVEMENT IN PAYMENT FOR NEW TECH-
36 NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.
37 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after “the

1 estimated average cost of such service or technology” the fol-
2 lowing: “(based on the marginal rate applied to costs under
3 subparagraph (A))”.

4 (e) ESTABLISHMENT OF NEW FUNDING FOR HOSPITAL
5 INPATIENT TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42
6 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking “sub-
7 ject to paragraph (4)(C)(iii),”.

8 (f) EFFECTIVE DATE.—

9 (1) IN GENERAL.—The Secretary shall implement the
10 amendments made by this section so that they apply to
11 classification for fiscal years beginning with fiscal year
12 2005.

13 (2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL
14 YEAR 2003 THAT ARE DENIED.—In the case of an applica-
15 tion for a classification of a medical service or technology
16 as a new medical service or technology under section
17 1886(d)(5)(K) of the Social Security Act (42 U.S.C.
18 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and
19 that is denied—

20 (A) the Secretary shall automatically reconsider
21 the application as an application for fiscal year 2005
22 under the amendments made by this section; and

23 (B) the maximum time period otherwise permitted
24 for such classification of the service or technology shall
25 be extended by 12 months.

26 **SEC. 503. INCREASE IN FEDERAL RATE FOR HOSPITALS**
27 **IN PUERTO RICO.**

28 Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is
29 amended—

30 (1) in subparagraph (A)—

31 (A) in clause (i), by striking “for discharges begin-
32 ning on or after October 1, 1997, 50 percent (and for
33 discharges between October 1, 1987, and September
34 30, 1997, 75 percent)” and inserting “the applicable
35 Puerto Rico percentage (specified in subparagraph
36 (E))”; and

1 (B) in clause (ii), by striking “for discharges be-
2 ginning in a fiscal year beginning on or after October
3 1, 1997, 50 percent (and for discharges between Octo-
4 ber 1, 1987, and September 30, 1997, 25 percent)”
5 and inserting “the applicable Federal percentage (spec-
6 ified in subparagraph (E))”; and

7 (2) by adding at the end the following new subpara-
8 graph:

9 “(E) For purposes of subparagraph (A), for discharges
10 occurring—

11 “(i) on or after October 1, 1987, and before October
12 1, 1997, the applicable Puerto Rico percentage is 75 per-
13 cent and the applicable Federal percentage is 25 percent;

14 “(ii) on or after October 1, 1997, and before October
15 1, 2003, the applicable Puerto Rico percentage is 50 per-
16 cent and the applicable Federal percentage is 50 percent;

17 “(iii) during fiscal year 2004, the applicable Puerto
18 Rico percentage is 41 percent and the applicable Federal
19 percentage is 59 percent;

20 “(iv) during fiscal year 2005, the applicable Puerto
21 Rico percentage is 33 percent and the applicable Federal
22 percentage is 67 percent; and

23 “(v) on or after October 1, 2005, the applicable Puer-
24 to Rico percentage is 25 percent and the applicable Federal
25 percentage is 75 percent.”.

26 **SEC. 504. WAGE INDEX ADJUSTMENT RECLASSIFICA-**
27 **TION REFORM .**

28 (a) IN GENERAL.—Section 1886(d) (42 U.S.C.
29 1395ww(d)) is amended by adding at the end the following:

30 “(11)(A) In order to recognize commuting patterns among
31 Metropolitan Statistical Areas and between such Areas and
32 rural areas, the Secretary shall establish a process, upon appli-
33 cation of a subsection (d) hospital that establishes that it is a
34 qualifying hospital described in subparagraph (B), for an in-
35 crease of the wage index applied under paragraph (3)(E) for
36 the hospital in the amount computed under subparagraph (D).

1 “(B) A qualifying hospital described in this subparagraph
2 is a subsection (d) hospital—

3 “(i) the average wages of which exceed the average
4 wages for the area in which the hospital is located; and

5 “(ii) which has at least 10 percent of its employees
6 who reside in one or more higher wage index areas.

7 “(C) For purposes of this paragraph, the term ‘higher
8 wage index area’ means, with respect to a hospital, an area
9 with a wage index that exceeds that of the area in which the
10 hospital is located.

11 “(D) The increase in the wage index under subparagraph
12 (A) for a hospital shall be equal to the percentage of the em-
13 ployees of the hospital that resides in any higher wage index
14 area multiplied by the sum of the products, for each higher
15 wage index area of—

16 “(i) the difference between (I) the wage index for such
17 area, and (II) the wage index of the area in which the hos-
18 pital is located (before the application of this paragraph);
19 and

20 “(ii) the number of employees of the hospital that re-
21 side in such higher wage index area divided by the total
22 number of such employees that reside in all high wage
23 index areas.

24 “(E) The process under this paragraph shall be based
25 upon the process used by the Medicare Geographic Classifica-
26 tion Review Board under paragraph (10) with respect to data
27 submitted by hospitals to the Board on the location of resi-
28 dence of hospital employees and wages under the applicable
29 schedule established for geographic reclassification.

30 “(F) A reclassification under this paragraph shall be effec-
31 tive for a period of 3 fiscal years, except that the Secretary
32 shall establish procedures under which a subsection (d) hospital
33 may elect to terminate such reclassification before the end of
34 such period.

35 “(G) A hospital that is reclassified under this paragraph
36 for a period is not eligible for reclassification under paragraphs
37 (8) or (10) during that period.

1 “(H) Any increase in a wage index under this paragraph
2 for a hospital shall not be taken into account for purposes of—

3 “(i) computing the wage index for the area in which
4 the hospital is located or any other area; or

5 “(ii) applying any budget neutrality adjustment with
6 respect to such index under paragraph (8)(D).”.

7 (b) EFFECTIVE DATE.—The amendment made by sub-
8 section (a) shall first apply to the wage index for cost reporting
9 period beginning on or after October 1, 2004.

10 **SEC. 505. MEDPAC REPORT ON SPECIALTY HOSPITALS.**

11 (a) MEDPAC STUDY.—The Medicare Payment Advisory
12 Commission shall conduct a study of specialty hospitals com-
13 pared with other similar general acute care hospitals under the
14 medicare program. Such study shall examine—

15 (1) whether there are excessive self-referrals;

16 (2) quality of care furnished;

17 (3) the impact of specialty hospitals on such general
18 acute care hospitals; and

19 (4) differences in the scope of services, medicaid utili-
20 zation, and uncompensated care furnished.

21 (b) REPORT.—Not later than 1 year after the date of the
22 enactment of this Act, the Secretary shall submit to Congress
23 a report on the study conducted under subsection (a), and shall
24 include any recommendations for legislation or administrative
25 change as the Secretary determines appropriate.

26 **Subtitle B—Other Provisions**

27 **SEC. 511. PAYMENT FOR COVERED SKILLED NURSING**
28 **FACILITY SERVICES.**

29 (a) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—
30 Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is
31 amended to read as follows:

32 “(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

33 “(A) IN GENERAL.—Subject to subparagraph (B),
34 in the case of a resident of a skilled nursing facility
35 who is afflicted with acquired immune deficiency syn-
36 drome (AIDS), the per diem amount of payment other-

1 wise applicable shall be increased by 128 percent to re-
2 flect increased costs associated with such residents.

3 “(B) SUNSET.—Subparagraph (A) shall not apply
4 on and after such date as the Secretary certifies that
5 there is an appropriate adjustment in the case mix
6 under paragraph (4)(G)(i) to compensate for the in-
7 creased costs associated with residents described in
8 such subparagraph.”.

9 (b) EFFECTIVE DATE.—The amendment made by para-
10 graph (1) shall apply to services furnished on or after October
11 1, 2003.

12 **SEC. 512. COVERAGE OF HOSPICE CONSULTATION SERV-**
13 **ICES.**

14 (a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—
15 Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

16 (1) by striking “and” at the end of paragraph (3);

17 (2) by striking the period at the end of paragraph (4)
18 and inserting “; and”; and

19 (3) by inserting after paragraph (4) the following new
20 paragraph:

21 “(5) for individuals who are terminally ill, have not
22 made an election under subsection (d)(1), and have not
23 previously received services under this paragraph, services
24 that are furnished by a physician who is either the medical
25 director or an employee of a hospice program and that con-
26 sist of—

27 “(A) an evaluation of the individual’s need for
28 pain and symptom management;

29 “(B) counseling the individual with respect to end-
30 of-life issues and care options; and

31 “(C) advising the individual regarding advanced
32 care planning.”.

33 (b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is
34 amended by adding at the end the following new paragraph:

35 “(4) The amount paid to a hospice program with respect
36 to the services under section 1812(a)(5) for which payment
37 may be made under this part shall be equal to an amount

1 equivalent to the amount established for an office or other out-
2 patient visit for evaluation and management associated with
3 presenting problems of moderate severity under the fee sched-
4 ule established under section 1848(b), other than the portion
5 of such amount attributable to the practice expense compo-
6 nent.”.

7 (c) CONFORMING AMENDMENT.—Section
8 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended
9 by inserting before the comma at the end the following: “and
10 services described in section 1812(a)(5)”.

11 (d) EFFECTIVE DATE.—The amendments made by this
12 section shall apply to services provided by a hospice program
13 on or after January 1, 2004.

14 **TITLE VI—PROVISIONS RELATING**
15 **TO PART B**
16 **Subtitle A—Physicians’ Services**

17 **SEC. 601. REVISION OF UPDATES FOR PHYSICIANS’**
18 **SERVICES.**

19 (a) UPDATE FOR 2004 AND 2005.—

20 (1) IN GENERAL.—Section 1848(d) (42 U.S.C.
21 1395w-4(d)) is amended by adding at the end the following
22 new paragraph:

23 “(5) UPDATE FOR 2004 AND 2005.—The update to the
24 single conversion factor established in paragraph (1)(C) for
25 each of 2004 and 2005 shall be not less than 1.5 percent.”.

26 (2) CONFORMING AMENDMENT.—Paragraph (4)(B) of
27 such section is amended, in the matter before clause (i), by
28 inserting “and paragraph (5)” after “subparagraph (D)”.

29 (3) NOT TREATED AS CHANGE IN LAW AND REGULA-
30 TION IN SUSTAINABLE GROWTH RATE DETERMINATION.—
31 The amendments made by this subsection shall not be
32 treated as a change in law for purposes of applying section
33 1848(f)(2)(D) of the Social Security Act (42 U.S.C.
34 1395w-4(f)(2)(D)).

35 (b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING
36 GROSS DOMESTIC PRODUCT.—

1 (1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C.
2 1395w-4(f)(2)(C)) is amended—

3 (A) by striking “projected” and inserting “annual
4 average”; and

5 (B) by striking “from the previous applicable pe-
6 riod to the applicable period involved” and inserting
7 “during the 10-year period ending with the applicable
8 period involved”.

9 (2) EFFECTIVE DATE.—The amendment made by
10 paragraph (1) shall apply to computations of the sustain-
11 able growth rate for years beginning with 2003.

12 **SEC. 602. STUDIES ON ACCESS TO PHYSICIANS’ SERV-**
13 **ICES.**

14 (a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-
15 CIANS’ SERVICES.—

16 (1) STUDY.—The Comptroller General of the United
17 States shall conduct a study on access of medicare bene-
18 ficiaries to physicians’ services under the medicare pro-
19 gram. The study shall include—

20 (A) an assessment of the use by beneficiaries of
21 such services through an analysis of claims submitted
22 by physicians for such services under part B of the
23 medicare program;

24 (B) an examination of changes in the use by bene-
25 ficiaries of physicians’ services over time;

26 (C) an examination of the extent to which physi-
27 cians are not accepting new medicare beneficiaries as
28 patients.

29 (2) REPORT.—Not later than 18 months after the
30 date of the enactment of this Act, the Comptroller General
31 shall submit to Congress a report on the study conducted
32 under paragraph (1). The report shall include a determina-
33 tion whether—

34 (A) data from claims submitted by physicians
35 under part B of the medicare program indicate poten-
36 tial access problems for medicare beneficiaries in cer-
37 tain geographic areas; and

1 (B) access by medicare beneficiaries to physicians'
2 services may have improved, remained constant, or de-
3 teriorated over time.

4 (b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

5 (1) STUDY.—The Secretary shall request the Institute
6 of Medicine of the National Academy of Sciences to con-
7 duct a study on the adequacy of the supply of physicians
8 (including specialists) in the United States and the factors
9 that affect such supply.

10 (2) REPORT TO CONGRESS.—Not later than 2 years
11 after the date of enactment of this section, the Secretary
12 shall submit to Congress a report on the results of the
13 study described in paragraph (1), including any rec-
14 ommendations for legislation.

15 **SEC. 603. MEDPAC REPORT ON PAYMENT FOR PHYSI-**
16 **CIAANS' SERVICES.**

17 Not later than 1 year after the date of the enactment of
18 this Act, the Medicare Payment Advisory Commission shall
19 submit to Congress a report on the effect of refinements to the
20 practice expense component of payments for physicians' serv-
21 ices, after the transition to a full resource-based payment sys-
22 tem in 2002, under section 1848 of the Social Security Act (42
23 U.S.C. 1395w-4). Such report shall examine the following mat-
24 ters by physician specialty:

25 (1) The effect of such refinements on payment for
26 physicians' services.

27 (2) The interaction of the practice expense component
28 with other components of and adjustments to payment for
29 physicians' services under such section.

30 (3) The appropriateness of the amount of compensa-
31 tion by reason of such refinements.

32 (4) The effect of such refinements on access to care
33 by medicare beneficiaries to physicians' services.

34 (5) The effect of such refinements on physician par-
35 ticipation under the medicare program.

Subtitle B—Preventive Services

SEC. 611. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking “and” at the end;

(2) in subparagraph (V), by inserting “and” at the end; and

(3) by adding at the end the following new subparagraph:

“(W) an initial preventive physical examination (as defined in subsection (ww));”.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Initial Preventive Physical Examination

“(ww) The term ‘initial preventive physical examination’ means physicians’ services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services (excluding clinical laboratory tests), as determined by the Secretary, consistent with the recommendations of the United States Preventive Services Task Force.”.

(c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

(1) DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking “and” before “(6)”, and

(B) by inserting before the period at the end the following: “, and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))”.

(2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) in clause (N), by inserting “(or 100 percent in the case of an initial preventive physical examina-

1 tion, as defined in section 1861(ww))” after “80 per-
2 cent”; and

3 (B) in clause (O), by inserting “(or 100 percent
4 in the case of an initial preventive physical examina-
5 tion, as defined in section 1861(ww))” after “80 per-
6 cent”.

7 (d) PAYMENT AS PHYSICIANS’ SERVICES.—Section
8 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
9 “(2)(W),” after “(2)(S),”.

10 (e) OTHER CONFORMING AMENDMENTS.—Section 1862(a)
11 (42 U.S.C. 1395y(a)) is amended—

12 (1) in paragraph (1)—

13 (A) by striking “and” at the end of subparagraph
14 (H);

15 (B) by striking the semicolon at the end of sub-
16 paragraph (I) and inserting “, and”; and

17 (C) by adding at the end the following new sub-
18 paragraph:

19 “(J) in the case of an initial preventive physical exam-
20 ination, which is performed not later than 6 months after
21 the date the individual’s first coverage period begins under
22 part B;” and

23 (2) in paragraph (7), by striking “or (H)” and insert-
24 ing “(H), or (J)”.

25 (f) EFFECTIVE DATE.—The amendments made by this
26 section shall apply to services furnished on or after January 1,
27 2004, but only for individuals whose coverage period begins on
28 or after such date.

29 **SEC. 612. COVERAGE OF CHOLESTEROL AND BLOOD**
30 **LIPID SCREENING.**

31 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
32 1395x(s)(2)), as amended by section 611(a), is amended—

33 (1) in subparagraph (V), by striking “and” at the end;

34 (2) in subparagraph (W), by inserting “and” at the
35 end; and

36 (3) by adding at the end the following new subpara-
37 graph:

1 “(X) cholesterol and other blood lipid screening
2 tests (as defined in subsection (XX));”.

3 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
4 1395x), as amended by section 611(b), is amended by adding
5 at the end the following new subsection:

6 “Cholesterol and Other Blood Lipid Screening Test

7 “(xx)(1) The term ‘cholesterol and other blood lipid
8 screening test’ means diagnostic testing of cholesterol and other
9 lipid levels of the blood for the purpose of early detection of
10 abnormal cholesterol and other lipid levels.

11 “(2) The Secretary shall establish standards, in consulta-
12 tion with appropriate organizations, regarding the frequency
13 and type of cholesterol and other blood lipid screening tests, ex-
14 cept that such frequency may not be more often than once
15 every 2 years.”.

16 (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.
17 1395y(a)(1)), as amended by section 611(e), is amended—

18 (1) by striking “and” at the end of subparagraph (I);

19 (2) by striking the semicolon at the end of subpara-
20 graph (J) and inserting “; and”; and

21 (3) by adding at the end the following new subpara-
22 graph:

23 “(K) in the case of a cholesterol and other blood lipid
24 screening test (as defined in section 1861(xx)(1)), which is
25 performed more frequently than is covered under section
26 1861(xx)(2).”.

27 (d) EFFECTIVE DATE.—The amendments made by this
28 section shall apply to tests furnished on or after January 1,
29 2005.

30 **SEC. 613. WAIVER OF DEDUCTIBLE FOR COLORECTAL**
31 **CANCER SCREENING TESTS.**

32 (a) IN GENERAL.—The first sentence of section 1833(b)
33 (42 U.S.C. 1395l(b)), as amended by section 611(c)(1), is
34 amended—

35 (1) by striking “and” before “(7)”; and

36 (2) by inserting before the period at the end the fol-
37 lowing: “, and (8) such deductible shall not apply with re-

1 spect to colorectal cancer screening tests (as described in
2 section 1861(pp)(1))”.

3 (b) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii)
4 and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395m(d)) are
5 each amended—

6 (1) by striking “DEDUCTIBLE AND” in the heading;
7 and

8 (2) in subclause (I), by striking “deductible or” each
9 place it appears.

10 (c) EFFECTIVE DATE.—The amendment made by this sec-
11 tion shall apply to items and services furnished on or after
12 January 1, 2004.

13 **SEC. 614. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**
14 **RAPHY SERVICES.**

15 (a) EXCLUSION FROM OPD FEE SCHEDULE.—Section
16 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by
17 inserting before the period at the end the following: “and does
18 not include screening mammography (as defined in section
19 1861(jj)) and unilateral and bilateral diagnostic mammo-
20 graphy”.

21 (b) ADJUSTMENT TO TECHNICAL COMPONENT.—For diag-
22 nostic mammography performed on or after January 1, 2004,
23 for which payment is made under the physician fee schedule
24 under section 1848 of the Social Security Act (42 U.S.C.
25 1395w-4), the Secretary, based on the most recent cost data
26 available, shall provide for an appropriate adjustment in the
27 payment amount for the technical component of the diagnostic
28 mammography.

29 (c) EFFECTIVE DATE.—The amendment made by sub-
30 section (a) shall apply to mammography performed on or after
31 January 1, 2004.

32 **Subtitle C—Other Services**

33 **SEC. 621. HOSPITAL OUTPATIENT DEPARTMENT (HOPD)**
34 **PAYMENT REFORM.**

35 (a) PAYMENT FOR DRUGS.—

1 (1) MODIFICATION OF AMBULATORY PAYMENT CLASSI-
2 FICATION (APC) GROUPS.—Section 1833(t) (42 U.S.C.
3 1395l(t)) is amended—

4 (A) by redesignating paragraph (13) as paragraph
5 (14); and

6 (B) by inserting after paragraph (12) the fol-
7 lowing new paragraph:

8 “(13) DRUG APC PAYMENT RATES.—

9 “(A) IN GENERAL.—With respect to payment for
10 covered OPD services that includes a specified covered
11 outpatient drug (defined in subparagraph (B)), the
12 amount provided for payment for such drug under the
13 payment system under this subsection for services fur-
14 nished in—

15 “(i) 2004, 2005, or 2006, shall in no case—

16 “(I) exceed 95 percent of the average
17 wholesale price for the drug; or

18 “(II) be less than the transition percent-
19 age (under subparagraph (C)) of the average
20 wholesale price for the drug; or

21 “(ii) a subsequent year, shall be equal to the
22 average price for the drug for that area and year
23 established under the competitive acquisition pro-
24 gram under section 1847A as calculated and ap-
25 plied by the Secretary for purposes of this para-
26 graph.

27 “(B) SPECIFIED COVERED OUTPATIENT DRUG DE-
28 FINED.—

29 “(i) IN GENERAL.—In this paragraph, the
30 term ‘specified covered outpatient drug’ means,
31 subject to clause (ii), a covered outpatient drug (as
32 defined in 1927(k)(2), that is—

33 “(I) a radiopharmaceutical; or

34 “(II) a drug or biological for which pay-
35 ment was made under paragraph (6) (relating
36 to pass-through payments) on or before Decem-
37 ber 31, 2002.

1 “(ii) EXCEPTION.—Such term does not
2 include—

3 “(I) a drug for which payment is first
4 made on or after January 1, 2003, under para-
5 graph (6); or

6 “(II) a drug for a which a temporary
7 HCPCS code has not been assigned.

8 “(C) TRANSITION TOWARDS HISTORICAL AVERAGE
9 ACQUISITION COST.—The transition percentage under
10 this subparagraph for drugs furnished in a year is de-
11 termined in accordance with the following table:

The transition percentage for—			
For the year—	Single source drugs are—	Innovator mul- tiple source drugs are—	Generic drugs are—
2004	83%	81.5%	46%
2005	77%	75%	46%
2006	71%	68%	46%

12 “(D) PAYMENT FOR NEW DRUGS UNTIL TEM-
13 PORARY HCPCS CODE ASSIGNED.—With respect to
14 payment for covered OPD services that includes a cov-
15 ered outpatient drug (as defined in 1927(k)) for a
16 which a temporary HCPCS code has not been assigned,
17 the amount provided for payment for such drug under
18 the payment system under this subsection shall be
19 equal to 95 percent of the average wholesale price for
20 the drug.

21 “(E) CLASSES OF DRUGS.—For purposes of this
22 paragraph, each of the following shall be treated as a
23 separate class of drugs:

24 “(i) SOLE SOURCE DRUGS.—A sole source
25 drug which for purposes of this paragraph means
26 a drug or biological that is not a multiple source
27 drug (as defined in subclauses (I) and (II) of sec-
28 tion 1927(k)(7)(A)(i)) and is not a drug approved
29 under an abbreviated new drug application under
30 section 355(j) of the Federal Food, Drug, and Cos-
31 metic Act.

1 “(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—
2 Innovator multiple source drugs (as defined in sec-
3 tion 1927(k)(7)(A)(ii)).

4 “(iii) NONINNOVATOR MULTIPLE SOURCE
5 DRUGS.—Noninnovator multiple source drugs (as
6 defined in section 1927(k)(7)(A)(iii)).

7 “(F) INAPPLICABILITY OF EXPENDITURES IN DE-
8 TERMINING CONVERSION FACTORS.—Additional ex-
9 penditures resulting from this paragraph and para-
10 graph (14)(C) in a year shall not be taken into account
11 in establishing the conversion factor for that year.”.

12 (2) REDUCTION IN THRESHOLD FOR SEPARATE APCS
13 FOR DRUGS.—Section 1833(t)(14), as redesignated by
14 paragraph (1)(A), is amended by adding at the end the fol-
15 lowing new subparagraph:

16 “(B) THRESHOLD FOR ESTABLISHMENT OF SEPA-
17 RATE APCS FOR DRUGS.—The Secretary shall reduce
18 the threshold for the establishment of separate ambula-
19 tory procedure classification groups (APCs) with re-
20 spect to drugs to \$50 per administration.”.

21 (3) EXCLUSION OF SEPARATE DRUG APCS FROM
22 OUTLIER PAYMENTS.—Section 1833(t)(5) is amended by
23 adding at the end the following new subparagraph:

24 “(E) EXCLUSION OF SEPARATE DRUG APCS FROM
25 OUTLIER PAYMENTS.—No additional payment shall be
26 made under subparagraph (A) in the case of ambula-
27 tory procedure codes established separately for drugs.”.

28 (4) PAYMENT FOR PASS THROUGH DRUGS.—Clause (i)
29 of section 1833(t)(6)(D) (42 U.S.C. 1395l(t)(6)(D)) is
30 amended by inserting after “under section 1842(o)” the
31 following: “(or if the drug is covered under a competitive
32 acquisition contract under section 1847A for an area, an
33 amount determined by the Secretary equal to the average
34 price for the drug for that area and year established under
35 such section as calculated and applied by the Secretary for
36 purposes of this paragraph)”.

1 (5) EFFECTIVE DATE.—The amendments made by
2 this subsection shall apply to services furnished on or after
3 January 1, 2004.

4 (b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

5 (1) IN GENERAL.—Section 1833(t)(14), as so redesign-
6 nated and amended by subsection (a)(2), is amended by
7 adding at the end the following new subparagraph:

8 “(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY
9 AT CHARGES ADJUSTED TO COST.—Notwithstanding
10 the preceding provisions of this subsection, for a device
11 of brachytherapy furnished on or after January 1,
12 2004, and before January 1, 2007, the payment basis
13 for the device under this subsection shall be equal to
14 the hospital’s charges for each device furnished, ad-
15 justed to cost.”.

16 (2) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY
17 DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2) is
18 amended—

19 (A) in subparagraph (F), by striking “and” at the
20 end;

21 (B) in subparagraph (G), by striking the period at
22 the end and inserting “; and”; and

23 (C) by adding at the end the following new sub-
24 paragraph:

25 “(H) with respect to devices of brachytherapy, the
26 Secretary shall create additional groups of covered
27 OPD services that classify such devices separately from
28 the other services (or group of services) paid for under
29 this subsection in a manner reflecting the number, iso-
30 tope, and radioactive intensity of such devices fur-
31 nished, including separate groups for palladium-103
32 and iodine-125 devices.”.

33 (3) GAO REPORT.—The Comptroller General of the
34 United States shall conduct a study to determine appro-
35 priate payment amounts under section 1833(t)(13)(B) of
36 the Social Security Act, as added by paragraph (1), for de-
37 vices of brachytherapy. Not later than January 1, 2005,

1 the Comptroller General shall submit to Congress and the
2 Secretary a report on the study conducted under this para-
3 graph, and shall include specific recommendations for ap-
4 propriate payments for such devices.

5 (c) APPLICATION OF FUNCTIONAL EQUIVALENCE TEST.—

6 (1) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.
7 1395l(t)(6)) is amended by adding at the end the following
8 new subparagraph:

9 “(F) LIMITATION ON APPLICATION OF FUNC-
10 TIONAL EQUIVALENCE STANDARD.—The Secretary may
11 not apply a ‘functional equivalence’ payment standard
12 (including such standard promulgated on November 1,
13 2002) or any other similar standard in order to deem
14 a particular drug or biological to be identical to or
15 similar to another drug or biological with respect to its
16 mechanism of action or clinical effect to deny pass-
17 through status to new drugs or biologics or to remove
18 such status of an existing eligible drug or biologic
19 under this paragraph unless—

20 “(i) the Secretary develops by regulation (after
21 providing notice and a period for public comment)
22 criteria for the application of such standard; and

23 “(ii) such criteria provide for coordination
24 with the Federal Food and Drug Administration
25 and require scientific studies that show the clinical
26 relationship between the drugs or biologicals treat-
27 ed as functionally equivalent.”.

28 (2) EFFECTIVE DATE.—The amendment made by
29 paragraph (1) shall apply to the application of a functional
30 equivalence standard to a drug or biological on or after the
31 date of the enactment of this Act, unless such application
32 was being made to such drug or biological prior to June
33 13, 2003.

34 (d) HOSPITAL ACQUISITION COST STUDY.—

35 (1) IN GENERAL.—The Secretary shall conduct a
36 study on the costs incurred by hospitals in acquiring cov-
37 ered outpatient drugs for which payment is made under

1 section 1833(t) of the Social Security Act (42 U.S.C.
2 1395l(t)).

3 (2) DRUGS COVERED.—The study in paragraph (1)
4 shall not include those drugs for which the acquisition costs
5 is less than \$50 per administration.

6 (3) REPRESENTATIVE SAMPLE OF HOSPITALS.—In
7 conducting the study under paragraph (1), the Secretary
8 shall collect data from a statistically valid sample of hos-
9 pitals with an urban/rural stratification.

10 (4) REPORT.—Not later than January 1, 2006, the
11 Secretary shall submit to Congress a report on the study
12 conducted under paragraph (1), and shall include rec-
13 ommendations with respect to the following:

14 (A) Whether the study should be repeated, and if
15 so, how frequently.

16 (B) Whether the study produced useful data on
17 hospital acquisition cost.

18 (C) Whether data produced in the study is appro-
19 priate for use in making adjustments to payments for
20 drugs and biologicals under section 1847A of the Social
21 Security Act.

22 (D) Whether separate estimates can made of over-
23 head costs, including handling and administering costs
24 for drugs.

25 **SEC. 622. PAYMENT FOR AMBULANCE SERVICES.**

26 (a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE
27 SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l)
28 (42 U.S.C. 1395m(l)), as amended by section 410(a), is
29 amended—

30 (1) in paragraph (2)(E), by inserting “consistent with
31 paragraph (11)” after “in an efficient and fair manner”;
32 and

33 (2) by adding at the end the following new paragraph:

34 “(11) PHASE-IN PROVIDING FLOOR USING BLEND OF
35 FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In car-
36 rying out the phase-in under paragraph (2)(E) for each
37 level of service furnished in a year, the portion of the pay-

1 ment amount that is based on the fee schedule shall not
2 be less than the following blended rate of the fee schedule
3 under paragraph (1) and of a regional fee schedule for the
4 region involved:

5 “(A) For 2004, the blended rate shall be based 20
6 percent on the fee schedule under paragraph (1) and
7 80 percent on the regional fee schedule.

8 “(B) For 2005, the blended rate shall be based 40
9 percent on the fee schedule under paragraph (1) and
10 60 percent on the regional fee schedule.

11 “(C) For 2006, the blended rate shall be based 60
12 percent on the fee schedule under paragraph (1) and
13 40 percent on the regional fee schedule.

14 “(D) For 2007, 2008, and 2009, the blended rate
15 shall be based 80 percent on the fee schedule under
16 paragraph (1) and 20 percent on the regional fee
17 schedule.

18 “(E) For 2010 and each succeeding year, the
19 blended rate shall be based 100 percent on the fee
20 schedule under paragraph (1).

21 For purposes of this paragraph, the Secretary shall estab-
22 lish a regional fee schedule for each of the 9 Census divi-
23 sions using the methodology (used in establishing the fee
24 schedule under paragraph (1)) to calculate a regional con-
25 version factor and a regional mileage payment rate and
26 using the same payment adjustments and the same relative
27 value units as used in the fee schedule under such para-
28 graph.”.

29 (b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG
30 TRIPS.—Section 1834(l), as amended by subsection (a), is fur-
31 ther amended by adding at the end the following new para-
32 graph:

33 “(12) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG
34 TRIPS.—In the case of ground ambulance services fur-
35 nished on or after January 1, 2004, and before January 1,
36 2009, regardless of where the transportation originates, the
37 fee schedule established under this subsection shall provide

1 that, with respect to the payment rate for mileage for a
2 trip above 50 miles the per mile rate otherwise established
3 shall be increased by $\frac{1}{4}$ of the payment per mile otherwise
4 applicable to such miles.”.

5 (c) GAO REPORT ON ACCESS.—Not later than December
6 31, 2005, the Comptroller General of the United States shall
7 submit to Congress an initial report on access and supply of
8 ambulance services in those regions and States that have a re-
9 duction in payment under the medicare ambulance fee schedule
10 (under section 1834(l) of the Social Security Act, as amended
11 by this section). Not later than December 31, 2007, the Comp-
12 troller General shall submit to Congress a final report on such
13 access and supply.

14 (d) EFFECTIVE DATE.—The amendments made by this
15 section shall apply to ambulance services furnished on or after
16 January 1, 2004.

17 **SEC. 623. RENAL DIALYSIS SERVICES.**

18 (a) DEMONSTRATION OF ALTERNATIVE DELIVERY MOD-
19 ELS.—

20 (1) USE OF ADVISORY BOARD.—In carrying out the
21 demonstration project relating to improving care for people
22 with end-stage renal disease through alternative delivery
23 models (as published in the Federal Register of June 4,
24 2003), the Secretary shall establish an advisory board com-
25 prised of representatives described in paragraph (2) to pro-
26 vide advice and recommendations with respect to the estab-
27 lishment and operation of such demonstration project.

28 (2) REPRESENTATIVES.—Representatives referred to
29 in paragraph (1) include representatives of the following:

30 (A) Patient organizations.

31 (B) Clinicians.

32 (C) The medicare payment advisory commission,
33 established under section 1805 of the Social Security
34 Act (42 U.S.C. 1395b–6).

35 (D) The National Kidney Foundation.

1 (E) The National Institute of Diabetes and Diges-
2 tive and Kidney Diseases of National Institutes of
3 Health.

4 (F) End-stage renal disease networks.

5 (G) Medicare contractors to monitor quality of
6 care.

7 (I) providers of services and renal dialysis facilities
8 furnishing end-stage renal disease services.

9 (J) Economists.

10 (K) Researchers.

11 (b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDI-
12 ATRIC FACILITIES.—

13 (1) IN GENERAL.—Section 422(a)(2) of BIPA is
14 amended—

15 (A) in subparagraph (A), by striking “and (C)”
16 and inserting “, (C), and (D)”;

17 (B) in subparagraph (B), by striking “In the
18 case” and inserting “Subject to subparagraph (D), in
19 the case”; and

20 (C) by adding at the end the following new sub-
21 paragraph:

22 “(D) INAPPLICABILITY TO PEDIATRIC FACILI-
23 TIES.—Subparagraphs (A) and (B) shall not apply, as
24 of October 1, 2002, to pediatric facilities that do not
25 have an exception rate described in subparagraph (C)
26 in effect on such date. For purposes of this subpara-
27 graph, the term ‘pediatric facility’ means a renal facil-
28 ity at least 50 percent of whose patients are individuals
29 under 18 years of age.”.

30 (2) CONFORMING AMENDMENT.—The fourth sentence
31 of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)), as amend-
32 ed by subsection (b), is further amended by striking
33 “Until” and inserting “Subject to section 422(a)(2) of the
34 Medicare, Medicaid, and SCHIP Benefits Improvement and
35 Protection Act of 2000, and until”.

36 (c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR
37 SERVICES FURNISHED IN 2004.—Notwithstanding any other

1 provision of law, with respect to payment under part B of title
2 XVIII of the Social Security Act for renal dialysis services fur-
3 nished in 2004, the composite payment rate otherwise estab-
4 lished under section 1881(b)(7) of such Act (42 U.S.C.
5 1395rr(b)(7)) shall be increased by 1.6 percent.

6 **SEC. 624. ONE-YEAR MORATORIUM ON THERAPY CAPS;**
7 **PROVISIONS RELATING TO REPORTS.**

8 (a) 1-YEAR MORATORIUM ON THERAPY CAPS.—Section
9 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking
10 “and 2002” and inserting “2002, and 2004”.

11 (b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAY-
12 MENT AND UTILIZATION OF OUTPATIENT THERAPY SERV-
13 ICES.—Not later than December 31, 2003, the Secretary shall
14 submit to Congress the reports required under section
15 4541(d)(2) of the Balanced Budget Act of 1997 (relating to al-
16 ternatives to a single annual dollar cap on outpatient therapy)
17 and under section 221(d) of the Medicare, Medicaid, and
18 SCHIP Balanced Budget Refinement Act of 1999 (relating to
19 utilization patterns for outpatient therapy).

20 (c) IDENTIFICATION OF CONDITIONS AND DISEASES JUS-
21 TIFYING WAIVER OF THERAPY CAP.—

22 (1) STUDY.—The Secretary shall request the Institute
23 of Medicine of the National Academy of Sciences to identify
24 conditions or diseases that should justify conducting an as-
25 sessment of the need to waive the therapy caps under sec-
26 tion 1833(g)(4) of the Social Security Act (42 U.S.C.
27 1395l(g)(4)).

28 (2) REPORTS TO CONGRESS.—

29 (A) PRELIMINARY REPORT.—Not later than July
30 1, 2004, the Secretary shall submit to Congress a pre-
31 liminary report on the conditions and diseases identi-
32 fied under paragraph (1).

33 (B) FINAL REPORT.—Not later than September 1,
34 2004, the Secretary shall submit to Congress a final re-
35 port on such conditions and diseases.

36 (C) RECOMMENDATIONS.—Not later than October
37 1, 2004, the Secretary shall submit to Congress a rec-

1 ommendation of criteria, with respect to such condi-
2 tions and disease, under which a waiver of the therapy
3 caps would apply.

4 (d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL
5 THERAPIST SERVICES.—

6 (1) STUDY.—The Comptroller General of the United
7 States shall conduct a study on access to physical therapist
8 services in States authorizing such services without a physi-
9 cian referral and in States that require such a physician re-
10 ferral. The study shall—

11 (A) examine the use of and referral patterns for
12 physical therapist services for patients age 50 and older
13 in States that authorize such services without a physi-
14 cian referral and in States that require such a physi-
15 cian referral;

16 (B) examine the use of and referral patterns for
17 physical therapist services for patients who are medi-
18 care beneficiaries;

19 (C) examine the potential effect of prohibiting a
20 physician from referring patients to physical therapy
21 services owned by the physician and provided in the
22 physician's office;

23 (D) examine the delivery of physical therapists'
24 services within the facilities of Department of Defense;
25 and

26 (E) analyze the potential impact on medicare
27 beneficiaries and on expenditures under the medicare
28 program of eliminating the need for a physician refer-
29 ral and physician certification for physical therapist
30 services under the medicare program.

31 (2) REPORT.—The Comptroller General shall submit
32 to Congress a report on the study conducted under para-
33 graph (1) by not later than 1 year after the date of the
34 enactment of this Act.

1 **SEC. 625. ADJUSTMENT TO PAYMENTS FOR SERVICES**
2 **FURNISHED IN AMBULATORY SURGICAL**
3 **CENTERS.**

4 Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is
5 amended in the last sentence by inserting “and each of fiscal
6 years 2004 through 2008” after “In each of the fiscal years
7 1998 through 2002”.

8 **SEC. 626. PAYMENT FOR CERTAIN SHOES AND INSERTS**
9 **UNDER THE FEE SCHEDULE FOR ORTHOTICS**
10 **AND PROSTHETICS.**

11 (a) IN GENERAL.—Section 1833(o) (42 U.S.C. 1395l(o))
12 is amended—

13 (1) in paragraph (1), by striking “no more than the
14 limits established under paragraph (2)” and inserting “no
15 more than the amount of payment applicable under para-
16 graph (2)”;

17 (2) in paragraph (2), to read as follows:

18 “(2)(A) Except as provided by the Secretary under sub-
19 paragraphs (B) and (C), the amount of payment under this
20 paragraph for custom molded shoes, extra depth shoes, and in-
21 serts shall be the amount determined for such items by the
22 Secretary under section 1834(h).

23 “(B) The Secretary or a carrier may establish payment
24 amounts for shoes and inserts that are lower than the amount
25 established under section 1834(h) if the Secretary finds that
26 shoes and inserts of an appropriate quality are readily available
27 at or below the amount established under such section.

28 “(C) In accordance with procedures established by the
29 Secretary, an individual entitled to benefits with respect to
30 shoes described in section 1861(s)(12) may substitute modifica-
31 tion of such shoes instead of obtaining one (or more, as speci-
32 fied by the Secretary) pair of inserts (other than the original
33 pair of inserts with respect to such shoes). In such case, the
34 Secretary shall substitute, for the payment amount established
35 under section 1834(h), a payment amount that the Secretary
36 estimates will assure that there is no net increase in expendi-
37 tures under this subsection as a result of this subparagraph.”.

1 (b) CONFORMING AMENDMENTS.—(1) Section
2 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by in-
3 serting “(and includes shoes described in section 1861(s)(12))”
4 after “in section 1861(s)(9)”.

5 (2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amend-
6 ed by striking subparagraph (C).

7 (c) EFFECTIVE DATE.—The amendments made by this
8 section shall apply to items furnished on or after January 1,
9 2004.

10 **SEC. 627. WAIVER OF PART B LATE ENROLLMENT PEN-**
11 **ALTY FOR CERTAIN MILITARY RETIREES;**
12 **SPECIAL ENROLLMENT PERIOD.**

13 (a) WAIVER OF PENALTY.—

14 (1) IN GENERAL.—Section 1839(b) (42 U.S.C.
15 1395r(b)) is amended by adding at the end the following
16 new sentence: “No increase in the premium shall be ef-
17 fected for a month in the case of an individual who is 65
18 years of age or older, who enrolls under this part during
19 2001, 2002, 2003, or 2004 and who demonstrates to the
20 Secretary before December 31, 2004, that the individual is
21 a covered beneficiary (as defined in section 1072(5) of title
22 10, United States Code). The Secretary of Health and
23 Human Services shall consult with the Secretary of De-
24 fense in identifying individuals described in the previous
25 sentence.”.

26 (2) EFFECTIVE DATE.—The amendment made by
27 paragraph (1) shall apply to premiums for months begin-
28 ning with January 2003. The Secretary of Health and
29 Human Services shall establish a method for providing re-
30 bates of premium penalties paid for months on or after
31 January 2003 for which a penalty does not apply under
32 such amendment but for which a penalty was previously
33 collected.

34 (b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

35 (1) IN GENERAL.—In the case of any individual who,
36 as of the date of the enactment of this Act, is 65 years of
37 age or older, is eligible to enroll but is not enrolled under

1 part B of title XVIII of the Social Security Act, and is a
2 covered beneficiary (as defined in section 1072(5) of title
3 10, United States Code), the Secretary of Health and
4 Human Services shall provide for a special enrollment pe-
5 riod during which the individual may enroll under such
6 part. Such period shall begin as soon as possible after the
7 date of the enactment of this Act and shall end on Decem-
8 ber 31, 2004.

9 (2) COVERAGE PERIOD.—In the case of an individual
10 who enrolls during the special enrollment period provided
11 under paragraph (1), the coverage period under part B of
12 title XVIII of the Social Security Act shall begin on the
13 first day of the month following the month in which the in-
14 dividual enrolls.

15 **SEC. 628. PART B DEDUCTIBLE.**

16 Section 1833(b) (42 U.S.C. 1395l(b)) is amended—

17 (1) by striking “1991 and” and inserting “1991,”;
18 and

19 (2) by striking “and subsequent years” and inserting
20 “and each subsequent year through 2003, and for a subse-
21 quent year after 2003 the amount of such deductible for
22 the previous year increased by the annual percentage in-
23 crease in the monthly actuarial rate under section
24 1839(a)(1) ending with such subsequent year (rounded to
25 the nearest \$1)”.

26 **TITLE VII—PROVISIONS RELATING**
27 **TO PARTS A AND B**
28 **Subtitle A—Home Health Services**

29 **SEC. 701. UPDATE IN HOME HEALTH SERVICES.**

30 (a) CHANGE TO CALENDER YEAR UPDATE.—

31 (1) IN GENERAL.—Section 1895(b) (42 U.S.C.
32 1395fff(b)(3)) is amended—

33 (A) in paragraph (3)(B)(i)—

34 (i) by striking “each fiscal year (beginning
35 with fiscal year 2002)” and inserting “fiscal year

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1 2002 and for fiscal year 2003 and for each subse-
2 quent year (beginning with 2004)”; and

3 (ii) by inserting “or year” after “the fiscal
4 year”;

5 (B) in paragraph (3)(B)(ii)(II), by striking “any
6 subsequent fiscal year” and inserting “2004 and any
7 subsequent year”;

8 (C) in paragraph (3)(B)(iii), by inserting “or
9 year” after “fiscal year” each place it appears;

10 (D) in paragraph (3)(B)(iv)—

11 (i) by inserting “or year” after “fiscal year”
12 each place it appears; and

13 (ii) by inserting “or years” after “fiscal
14 years”; and

15 (E) in paragraph (5), by inserting “or year” after
16 “fiscal year”.

17 (2) TRANSITION RULE.—The standard prospective
18 payment amount (or amounts) under section 1895(b)(3) of
19 the Social Security Act for the calendar quarter beginning
20 on October 1, 2003, shall be such amount (or amounts) for
21 the previous calendar quarter.

22 (b) CHANGES IN UPDATES FOR 2004, 2005, AND 2006.—
23 Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as
24 amended by subsection (a)(1)(B), is amended—

25 (1) by striking “or” at the end of subclause (I);

26 (2) by redesignating subclause (II) as subclause (III);

27 (3) in subclause (III), as so redesignated, by striking
28 “2004” and inserting “2007”; and

29 (4) by inserting after subclause (I) the following new
30 subclause:

31 “(II) each of 2004, 2005, and 2006 the
32 home health market basket percentage increase
33 minus 0.4 percentage points; or”.

34 **SEC. 702. ESTABLISHMENT OF REDUCED COPAYMENT**
35 **FOR A HOME HEALTH SERVICE EPISODE OF**
36 **CARE FOR CERTAIN BENEFICIARIES.**

37 (a) PART A.—

1 (1) IN GENERAL.—Section 1813(a) (42 U.S.C.
2 1395e(a)) is amended by adding at the end the following
3 new paragraph:

4 “(5)(A)(i) Subject to clause (ii), the amount payable for
5 home health services furnished to the individual under this title
6 for each episode of care beginning in a year (beginning with
7 2004) shall be reduced by a copayment equal to the copayment
8 amount specified in subparagraph (B)(ii) for such year.

9 “(ii) The copayment under clause (i) shall not apply—

10 “(I) in the case of an individual who has been deter-
11 mined to be entitled to medical assistance under section
12 1902(a)(10)(A) or 1902(a)(10)(C) or to be a qualified
13 medicare beneficiary (as defined in section 1905(p)(1)), a
14 specified low-income medicare beneficiary described in sec-
15 tion 1902(a)(10)(E)(iii), or a qualifying individual de-
16 scribed in section 1902(a)(10)(E)(iv)(I); and

17 “(II) in the case of an episode of care which consists
18 of 4 or fewer visits.

19 “(B)(i) The Secretary shall estimate, before the beginning
20 of each year (beginning with 2004), the national average pay-
21 ment under this title per episode for home health services pro-
22 jected for the year involved.

23 “(ii) For each year the copayment amount under this
24 clause is equal to 1.5 percent of the national average payment
25 estimated for the year involved under clause (i). Any amount
26 determined under the preceding sentence which is not a mul-
27 tiple of \$5 shall be rounded to the nearest multiple of \$5.

28 “(iii) There shall be no administrative or judicial review
29 under section 1869, 1878, or otherwise of the estimation of av-
30 erage payment under clause (i).”.

31 (2) TIMELY IMPLEMENTATION.—Unless the Secretary
32 of Health and Human Services otherwise provides on a
33 timely basis, the copayment amount specified under section
34 1813(a)(5)(B)(ii) of the Social Security Act (as added by
35 paragraph (1)) for 2004 shall be deemed to be \$40.

36 (b) CONFORMING PROVISIONS.—

1 (1) Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A))
2 is amended by inserting “less the copayment amount appli-
3 cable under section 1813(a)(5)” after “1895”.

4 (2) Section 1866(a)(2)(A)(i) (42 U.S.C.
5 1395cc(a)(2)(A)(i)) is amended—

6 (A) by striking “or coinsurance” and inserting “,
7 coinsurance, or copayment”; and

8 (B) by striking “or (a)(4)” and inserting “(a)(4),
9 or (a)(5)”.

10 **SEC. 703. MEDPAC STUDY ON MEDICARE MARGINS OF**
11 **HOME HEALTH AGENCIES.**

12 (a) STUDY.—The Medicare Payment Advisory Commission
13 shall conduct a study of payment margins of home health agen-
14 cies under the home health prospective payment system under
15 section 1895 of the Social Security Act (42 U.S.C. 1395fff).
16 Such study shall examine whether systematic differences in
17 payment margins are related to differences in case mix (as
18 measured by home health resource groups (HHRGs)) among
19 such agencies. The study shall use the partial or full-year cost
20 reports filed by home health agencies.

21 (b) REPORT.—Not later than 2 years after the date of the
22 enactment of this Act, the Commission shall submit to Con-
23 gress a report on the study under subsection (a).

24 **Subtitle B—Direct Graduate Medical**
25 **Education**

26 **SEC. 711. EXTENSION OF UPDATE LIMITATION ON HIGH**
27 **COST PROGRAMS.**

28 Section 1886(h)(2)(D)(iv) (42 U.S.C.
29 1395ww(h)(2)(D)(iv)) is amended—

30 (1) in subclause (I)—

31 (A) by inserting “AND 2004 THROUGH 2013” after
32 “AND 2002”; and

33 (B) by inserting “or during the period beginning
34 with fiscal year 2004 and ending with fiscal year 2013”
35 after “during fiscal year 2001 or fiscal year 2002”;
36 and

37 (2) in subclause (II)—

1 (A) by striking “fiscal year 2004, or fiscal year
2 2005,” and

3 (B) by striking “For a” and inserting “For the”.

4 **Subtitle C—Chronic Care**
5 **Improvement**

6 **SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT**
7 **UNDER TRADITIONAL FEE-FOR-SERVICE.**

8 Title XVIII, as amended by section 105(a), is amended by
9 inserting after section 1807 the following new section:

10 “CHRONIC CARE IMPROVEMENT

11 “SEC. 1808. (a) IN GENERAL.—

12 “(1) IN GENERAL.—The Secretary shall establish a
13 process for providing chronic care improvement programs
14 in each CCLIA region for medicare beneficiaries who are not
15 enrolled under part C or E and who have certain chronic
16 conditions, such as congestive heart failure, diabetes,
17 chronic obstructive pulmonary disease (COPD), stroke, or
18 other disease as identified by the Secretary as appropriate
19 for chronic care improvement. Such a process shall begin
20 to be implemented no later than 1 year after the date of
21 the enactment of this section.

22 “(2) TERMINOLOGY.—For purposes of this section:

23 “(A) CCLIA REGION.—The term ‘CCLIA region’
24 means a chronic care improvement administrative re-
25 gion delineated under subsection (b)(2).

26 “(B) CHRONIC CARE IMPROVEMENT PROGRAM.—
27 The terms ‘chronic care improvement program’ and
28 ‘program’ means such a program provided by a con-
29 tractor under this section.

30 “(C) CONTRACTOR.—The term ‘contractor’ means
31 an entity with a contract to provide a chronic care im-
32 provement program in a CCLIA region under this sec-
33 tion.

34 “(D) INDIVIDUAL PLAN.—The term ‘individual
35 plan’ means a chronic care improvement plan estab-
36 lished under subsection (c)(5) for an individual.

1 “(3) CONSTRUCTION.—Nothing in this section shall be
2 construed as expanding the amount, duration, or scope of
3 benefits under this title.

4 “(b) COMPETITIVE BIDDING PROCESS.—

5 “(1) IN GENERAL.—Under this section the Secretary
6 shall award contracts to qualified entities for chronic care
7 improvement programs for each CCIA region under this
8 section through a competitive bidding process.

9 “(2) PROCESS.—Under such process—

10 “(A) the Secretary shall delineate the United
11 States into multiple chronic care improvement adminis-
12 trative regions; and

13 “(B) the Secretary shall select at least 2 winning
14 bidders in each CCIA region on the basis of the ability
15 of each bidder to carry out a chronic care improvement
16 program in accordance with this section, in order to
17 achieve improved health and financial outcomes.

18 “(3) ELIGIBLE CONTRACTOR.—A contractor may be a
19 disease improvement organization, health insurer, provider
20 organization, a group of physicians, or any other legal enti-
21 ty that the Secretary determines appropriate.

22 “(c) CHRONIC CARE IMPROVEMENT PROGRAMS.—

23 “(1) IN GENERAL.—Each contract under this section
24 shall provide for the operation of a chronic care improve-
25 ment program by a contractor in a CCIA region consistent
26 with this subsection.

27 “(2) IDENTIFICATION OF PROSPECTIVE PROGRAM PAR-
28 TICIPANTS.—Each contractor shall have a method for iden-
29 tifying medicare beneficiaries in the region to whom it will
30 offer services under its program. The contractor shall iden-
31 tify such beneficiaries through claims or other data and
32 other means permitted consistent with applicable disclosure
33 provisions.

34 “(3) INITIAL CONTACT BY SECRETARY.—The Sec-
35 retary shall communicate with each beneficiary identified
36 under paragraph (2) as a prospective participant in one or
37 more programs concerning participation in a program.

1 Such communication may be made by the Secretary (or on
2 behalf of the Secretary) and shall include information on
3 the following:

4 “(A) A description of the advantages to the bene-
5 ficiary in participating in a program.

6 “(B) Notification that the contractor offering a
7 program may contact the beneficiary directly con-
8 cerning such participation.

9 “(C) Notification that participation in a program
10 is voluntary.

11 “(D) A description of the method for the bene-
12 ficiary to select the single program in which the bene-
13 ficiary wishes to participate and for declining to partici-
14 pate and a method for obtaining additional information
15 concerning such participation.

16 “(4) PARTICIPATION.—A medicare beneficiary may
17 participate in only one program under this section and may
18 terminate participation at any time in a manner specified
19 by the Secretary.

20 “(5) INDIVIDUAL CHRONIC CARE IMPROVEMENT
21 PLANS.—

22 “(A) IN GENERAL.—For each beneficiary partici-
23 pating in a program of a contractor under this section,
24 the contractor shall develop with the beneficiary an in-
25 dividualized, goal-oriented chronic care improvement
26 plan.

27 “(B) ELEMENTS OF INDIVIDUAL PLAN.—Each in-
28 dividual plan developed under subparagraph (A) shall
29 include a single point of contact to coordinate care and
30 the following, as appropriate:

31 “(i) Self-improvement education for the bene-
32 ficiary and support education for health care pro-
33 viders, primary caregivers, and family members.

34 “(ii) Coordination of health care services, such
35 as application of a prescription drug regimen and
36 home health services.

1 “(iii) Collaboration with physicians and other
2 providers to enhance communication of relevant
3 clinical information.

4 “(iv) The use of monitoring technologies that
5 enable patient guidance through the exchange of
6 pertinent clinical information, such as vital signs,
7 symptomatic information, and health self-assess-
8 ment.

9 “(v) The provision of information about hos-
10 pice care, pain and palliative care, and end-of-life
11 care.

12 “(C) CONTRACTOR RESPONSIBILITIES.—In estab-
13 lishing and carrying out individual plans under a pro-
14 gram, a contractor shall, directly or through
15 subcontractors—

16 “(i) guide participants in managing their
17 health, including all their co-morbidities, and in
18 performing activities as specified under the ele-
19 ments of the plan;

20 “(ii) use decision support tools such as evi-
21 dence-based practice guidelines or other criteria as
22 determined by the Secretary; and

23 “(iii) develop a clinical information database
24 to track and monitor each participant across set-
25 tings and to evaluate outcomes.

26 “(6) ADDITIONAL REQUIREMENTS.—The Secretary
27 may establish additional requirements for programs and
28 contractors under this section.

29 “(7) ACCREDITATION.—The Secretary may provide
30 that programs that are accredited by qualified organiza-
31 tions may be deemed to meet such requirements under this
32 section as the Secretary may specify.

33 “(c) CONTRACT TERMS.—

34 “(1) IN GENERAL.—A contract under this section shall
35 contain such terms and conditions as the Secretary may
36 specify consistent with this section. The Secretary may not
37 enter into a contract with an entity under this section un-

1 less the entity meets such clinical, quality improvement, fi-
2 nancial, and other requirements as the Secretary deems to
3 be appropriate for the population to be served.

4 “(2) USE OF SUBCONTRACTORS PERMITTED.—A con-
5 tractor may carry out a program directly or through con-
6 tracts with subcontractors.

7 “(3) BUDGET NEUTRAL PAYMENT CONDITION.—In en-
8 tering into a contract with an entity under this subsection,
9 the Secretary shall establish payment rates that assure that
10 there will be no net aggregate increase in payments under
11 this title over any period of 3 years or longer, as agreed
12 to by the Secretary. Under this section, the Secretary shall
13 assure that medicare program outlays plus administrative
14 expenses (that would not have been paid under this title
15 without implementation of this section), including con-
16 tractor fees, shall not exceed the expenditures that would
17 have been incurred under this title for a comparable popu-
18 lation in the absence of the program under this section for
19 the 3-year contract period.

20 “(4) AT RISK RELATIONSHIP.—For purposes of sec-
21 tion 1128B(b)(3)(F), a contract under this section shall be
22 treated as a risk-sharing arrangement referred to in such
23 section.

24 “(5) PERFORMANCE STANDARDS.—Payment to con-
25 tractors under this section shall be subject to the contrac-
26 tor’s meeting of clinical and financial performance stand-
27 ards set by the Secretary.

28 “(6) CONTRACTOR OUTCOMES REPORT.—Each con-
29 tractor offering a program shall monitor and report to the
30 Secretary, in a manner specified by the Secretary, the qual-
31 ity of care and efficacy of such program in terms of—

32 “(A) process measures, such as reductions in er-
33 rors of treatment and rehospitalization rates;

34 “(B) beneficiary and provider satisfaction;

35 “(C) health outcomes; and

36 “(D) financial outcomes.

1 “(7) PHASED IN IMPLEMENTATION.—Nothing in this
2 section shall be construed as preventing the Secretary from
3 phasing in the implementation of programs.

4 “(d) BIENNIAL OUTCOMES REPORTS.—The Secretary
5 shall submit to the Congress biennial reports on the implemen-
6 tation of this section. Each such report shall include informa-
7 tion on—

8 “(1) the scope of implementation (in terms of both re-
9 gions and chronic conditions);

10 “(2) program design; and

11 “(3) improvements in health outcomes and financial
12 efficiencies that result from such implementation.

13 “(e) CLINICAL TRIALS.—The Secretary shall conduct ran-
14 domized clinical trials, that compare program participants with
15 medicare beneficiaries who are offered, but decline, to partici-
16 pate, in order to assess the potential of programs to—

17 “(1) reduce costs under this title; and

18 “(2) improve health outcomes under this title.

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—There are
20 authorized to be appropriated to the Secretary, in appropriate
21 part from the Hospital Insurance Trust Fund and the Supple-
22 mentary Medical Insurance Trust Fund, such sums as may be
23 necessary to provide for contracts with chronic care improve-
24 ment programs under this section.

25 “(g) LIMITATION ON FUNDING.—In no case shall the
26 funding under this section exceed \$100,000,000 over a period
27 of 3 years.”.

28 **SEC. 722. CHRONIC CARE IMPROVEMENT UNDER MEDI-**
29 **CARE ADVANTAGE AND ENHANCED FEE-FOR-**
30 **SERVICE PROGRAMS.**

31 (a) UNDER MEDICARE ADVANTAGE PROGRAM.—Section
32 1852 (42 U.S.C. 1395w-22) is amended—

33 (1) by amending subsection (e) to read as follows:

34 “(e) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT
35 PROGRAMS FOR BENEFICIARIES WITH MULTIPLE OR SUFFI-
36 CIENTLY SEVERE CHRONIC CONDITIONS.—

1 “(1) IN GENERAL.—Each Medicare Advantage organi-
2 zation with respect to each Medicare Advantage plan it of-
3 fers shall have in effect, for enrollees with multiple or suffi-
4 ciently severe chronic conditions, a chronic care improve-
5 ment program that is designed to manage the needs of
6 such enrollees and that meets the requirements of this sub-
7 section.

8 “(2) ENROLLEE WITH MULTIPLE OR SUFFICIENTLY
9 SEVERE CHRONIC CONDITIONS.—For purposes of this sub-
10 section, the term ‘enrollee with multiple or sufficiently se-
11 vere chronic conditions’ means, with respect to an enrollee
12 in a Medicare Advantage plan of a Medicare Advantage or-
13 ganization, an enrollee in the plan who has one or more
14 chronic conditions, such as congestive heart failure, diabe-
15 tes, COPD, stroke, or other disease as identified by the or-
16 ganization as appropriate for chronic care improvement.

17 “(3) GENERAL REQUIREMENTS.—

18 “(A) IN GENERAL.—Each chronic care improve-
19 ment program under this subsection shall be conducted
20 consistent with this subsection.

21 “(B) IDENTIFICATION OF ENROLLEES.—Each
22 such program shall have a method for monitoring and
23 identifying enrollees with multiple or sufficiently severe
24 chronic conditions that meet the organization’s criteria
25 for participation under the program.

26 “(C) DEVELOPMENT OF PLANS.—For an enrollee
27 identified under subparagraph (B) for participation in
28 a program, the program shall develop, with the enroll-
29 ee’s consent, an individualized, goal-oriented chronic
30 care improvement plan for chronic care improvement.

31 “(D) ELEMENTS OF PLANS.—Each chronic care
32 improvement plan developed under subparagraph (C)
33 shall include a single point of contact to coordinate
34 care and the following, as appropriate:

35 “(i) Self-improvement education for the en-
36 rollee and support education for health care pro-
37 viders, primary caregivers, and family members.

1 “(ii) Coordination of health care services, such
2 as application of a prescription drug regimen and
3 home health services.

4 “(iii) Collaboration with physicians and other
5 providers to enhance communication of relevant
6 clinical information.

7 “(iv) The use of monitoring technologies that
8 enable patient guidance through the exchange of
9 pertinent clinical information, such as vital signs,
10 symptomatic information, and health self-assess-
11 ment.

12 “(v) The provision of information about hos-
13 pice care, pain and palliative care, and end-of-life
14 care.

15 “(E) ORGANIZATION RESPONSIBILITIES.—In es-
16 tablishing and carrying out chronic care improvement
17 plans for participants under this paragraph, a Medicare
18 Advantage organization shall, directly or through
19 subcontractors—

20 “(i) guide participants in managing their
21 health, including all their co-morbidities, and in
22 performing the activities as specified under the ele-
23 ments of the plan;

24 “(ii) use decision support tools such as evi-
25 dence-based practice guidelines or other criteria as
26 determined by the Secretary; and

27 “(iii) develop a clinical information database
28 to track and monitor each participant across set-
29 tings and to evaluate outcomes.

30 “(3) ADDITIONAL REQUIREMENTS.—The Secretary
31 may establish additional requirements for chronic care im-
32 provement programs under this section.

33 “(4) ACCREDITATION.—The Secretary may provide
34 that chronic care improvement programs that are accred-
35 ited by qualified organizations may be deemed to meet such
36 requirements under this subsection as the Secretary may
37 specify.

1 “(5) OUTCOMES REPORT.—Each Medicare Advantage
2 organization with respect to its chronic care improvement
3 program under this subsection shall monitor and report to
4 the Secretary information on the quality of care and effi-
5 cacy of such program as the Secretary may require.”; and
6 (2) by amending subparagraph (I) of subsection (c)(1)
7 to read as follows:

8 “(I) CHRONIC CARE IMPROVEMENT PROGRAM.—A
9 description of the organization’s chronic care improve-
10 ment program under subsection (e).”.

11 (b) APPLICATION UNDER ENHANCED FEE-FOR-SERVICE
12 PROGRAM.—Section 1860E-2(c)(3), as inserted by section
13 201(a), is amended by inserting “, including subsection (e) (re-
14 lating to implementation of chronic care improvement pro-
15 grams)” after “The provisions of section 1852”.

16 (c) EFFECTIVE DATE.—The amendments made by this
17 section shall apply for contract years beginning on or after 1
18 year after the date of the enactment of this Act.

19 **SEC. 723. INSTITUTE OF MEDICINE REPORT.**

20 (a) STUDY.—

21 (1) IN GENERAL.—The Secretary of Health and
22 Human Services shall contract with the Institute of Medi-
23 cine of the National Academy of Sciences to conduct a
24 study of the barriers to effective integrated care improve-
25 ment for medicare beneficiaries with multiple or severe
26 chronic conditions across settings and over time and to
27 submit a report under subsection (b).

28 (2) SPECIFIC ITEMS.—The study shall examine the
29 statutory and regulatory barriers to coordinating care
30 across settings for medicare beneficiaries in transition from
31 one setting to another (such as between hospital, nursing
32 facility, home health, hospice, and home). The study shall
33 specifically identify the following:

34 (A) Clinical, financial, or administrative require-
35 ments in the medicare program that present barriers to
36 effective, seamless transitions across care settings.

1 (B) Policies that impede the establishment of ad-
2 ministrative and clinical information systems to track
3 health status, utilization, cost, and quality data across
4 settings.

5 (C) State-level requirements that may present bar-
6 riers to better care for medicare beneficiaries.

7 (3) CONSULTATION.—The study under this subsection
8 shall be conducted in consultation with experts in the field
9 of chronic care, consumers, and family caregivers, working
10 to integrate care delivery and create more seamless transi-
11 tions across settings and over time.

12 (b) REPORT.—The report under this subsection shall be
13 submitted to the Secretary and Congress not later than 18
14 months after the date of the enactment of this Act.

15 **SEC. 724. MEDPAC REPORT.**

16 (a) EVALUATION.—shall conduct an evaluation that in-
17 cludes a description of the status of the implementation of
18 chronic care improvement programs under section 1808 of the
19 Social Security Act, the quality of health care services provided
20 to individuals in such program, the health status of the partici-
21 pants of such program, and the cost savings attributed to im-
22 plementation of such program.

23 (b) REPORT.—Not later than 2 years after the date of im-
24 plementation of such chronic care improvement programs, the
25 Commission shall submit a report on such evaluation.

26 **Subtitle D—Other Provisions**

27 **SEC. 731. MODIFICATIONS TO MEDICARE PAYMENT AD-**
28 **VISORY COMMISSION (MEDPAC).**

29 (a) EXAMINATION OF BUDGET CONSEQUENCES.—Section
30 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the
31 end the following new paragraph:

32 “(8) EXAMINATION OF BUDGET CONSEQUENCES.—Be-
33 fore making any recommendations, the Commission shall
34 examine the budget consequences of such recommendations,
35 directly or through consultation with appropriate expert en-
36 tities.”.

1 (b) CONSIDERATION OF EFFICIENT PROVISION OF SERV-
2 ICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b-
3 6(b)(2)(B)(i)) is amended by inserting “the efficient provision
4 of” after “expenditures for”.

5 (c) APPLICATION OF DISCLOSURE REQUIREMENTS.—

6 (1) IN GENERAL.—Section 1805(c)(2)(D) (42 U.S.C.
7 1395b-6(c)(2)(D)) is amended by adding at the end the
8 following: “Members of the Commission shall be treated as
9 employees of the Congress for purposes of applying title I
10 of the Ethics in Government Act of 1978 (Public Law 95-
11 521).”.

12 (2) EFFECTIVE DATE.—The amendment made by
13 paragraph (1) shall take effect on January 1, 2004.

14 (d) ADDITIONAL REPORTS.—

15 (1) DATA NEEDS AND SOURCES.—The Medicare Pay-
16 ment Advisory Commission shall conduct a study, and sub-
17 mit a report to Congress by not later than June 1, 2004,
18 on the need for current data, and sources of current data
19 available, to determine the solvency and financial cir-
20 cumstances of hospitals and other medicare providers of
21 services. The Commission shall examine data on uncompen-
22 sated care, as well as the share of uncompensated care ac-
23 counted for by the expenses for treating illegal aliens.

24 (2) USE OF TAX-RELATED RETURNS.—Using return
25 information provided under Form 990 of the Internal Rev-
26 enue Service, the Commission shall submit to Congress, by
27 not later than June 1, 2004, a report on the following:

28 (A) Investments, endowments, and fundraising of
29 hospitals participating under the medicare program and
30 related foundations.

31 (B) Access to capital financing for private and for
32 not-for-profit hospitals.

33 **SEC. 732. DEMONSTRATION PROJECT FOR MEDICAL**
34 **ADULT DAY CARE SERVICES.**

35 (a) ESTABLISHMENT.—Subject to the succeeding provi-
36 sions of this section, the Secretary of Health and Human Serv-
37 ices shall establish a demonstration project (in this section re-

ferred to as the “demonstration project”) under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary’s home.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 u.s.c. 1395fff). In no case may a home health agency, or a medical adult day care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day care services furnished under the plan of care.

(2) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

(c) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in not more than 5 States selected by the Secretary that license or certify providers of services that furnish medical adult day care services.

(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may par-

1 participate in the project at any given time may not exceed
2 15,000.

3 (f) PREFERENCE IN SELECTING AGENCIES.—In selecting
4 home health agencies to participate under the demonstration
5 project, the Secretary shall give preference to those agencies
6 that are currently licensed or certified through common owner-
7 ship and control to furnish medical adult day care services.

8 (g) WAIVER AUTHORITY.—The Secretary may waive such
9 requirements of title XVIII of the Social Security Act as may
10 be necessary for the purposes of carrying out the demonstra-
11 tion project, other than waiving the requirement that an indi-
12 vidual be homebound in order to be eligible for benefits for
13 home health services.

14 (h) EVALUATION AND REPORT.—The Secretary shall con-
15 duct an evaluation of the clinical and cost effectiveness of the
16 demonstration project. Not later 30 months after the com-
17 mencement of the project, the Secretary shall submit to Con-
18 gress a report on the evaluation, and shall include in the report
19 the following:

20 (1) An analysis of the patient outcomes and costs of
21 furnishing care to the medicare beneficiaries participating
22 in the project as compared to such outcomes and costs to
23 beneficiaries receiving only home health services for the
24 same health conditions.

25 (2) Such recommendations regarding the extension,
26 expansion, or termination of the project as the Secretary
27 determines appropriate.

28 (i) DEFINITIONS.—In this section:

29 (1) HOME HEALTH AGENCY.—The term “home health
30 agency” has the meaning given such term in section
31 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

32 (2) MEDICAL ADULT DAY CARE FACILITY.—The term
33 “medical adult day care facility” means a facility that—

34 (A) has been licensed or certified by a State to
35 furnish medical adult day care services in the State for
36 a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day care services.

(3) MEDICAL ADULT DAY CARE SERVICES.—The term “medical adult day care services” means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) MEDICARE BENEFICIARY.—The term “medicare beneficiary” means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 723. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting “consistent with subsection (k)” after “the Secretary shall ensure”; and

1 (B) by adding at the end the following new sub-
2 section:

3 “(k) NATIONAL AND LOCAL COVERAGE DETERMINATION
4 PROCESS.—

5 “(1) CRITERIA AND EVIDENCE USED IN MAKING NA-
6 TIONAL COVERAGE DETERMINATIONS.—The Secretary shall
7 establish by regulation (and after public comment) the cri-
8 teria the Secretary uses in making national coverage deter-
9 minations, including how evidence to demonstrate that a
10 procedure or device is reasonable and necessary is consid-
11 ered.

12 “(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR
13 NATIONAL COVERAGE DETERMINATIONS.—In the case of a
14 request for a national coverage determination that—

15 “(A) does not require a technology assessment
16 from an outside entity or deliberation from the Medi-
17 care Coverage Advisory Committee, the decision on the
18 request shall be made not later than 6 months after the
19 date of the request; or

20 “(B) requires such an assessment or deliberation
21 and in which a clinical trial is not requested, the deci-
22 sion on the request shall be made not later than 12
23 months after the date of the request.

24 “(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL
25 COVERAGE DETERMINATIONS.—At the end of the 6-month
26 period that begins on the date a request for a national cov-
27 erage determination is made, the Secretary shall—

28 “(A) make a draft of proposed decision on the re-
29 quest available to the public through the Medicare
30 Internet site of the Department of Health and Human
31 Services or other appropriate means;

32 “(B) provide a 30-day period for public comment
33 on such draft;

34 “(C) make a final decision on the request within
35 60 days of the conclusion of the 30-day period referred
36 to under subparagraph (B);

1 “(D) include in such final decision summaries of
2 the public comments received and responses thereto;
3 and

4 “(E) make available to the public the clinical evi-
5 dence and other data used in making such a decision
6 when the decision differs from the recommendations of
7 the Medicare Coverage Advisory Committee.

8 “(4) CONSULTATION WITH OUTSIDE EXPERTS IN CER-
9 TAIN NATIONAL COVERAGE DETERMINATIONS.—With re-
10 spect to a request for a national coverage determination for
11 which there is not a review by the Medicare Coverage Advi-
12 sory Committee, the Secretary shall consult with appro-
13 priate outside clinical experts.

14 “(5) LOCAL COVERAGE DETERMINATION PROCESS.—
15 With respect to local coverage determinations made on or
16 after January 1, 2004—

17 “(A) PLAN TO PROMOTE CONSISTENCY OF COV-
18 ERAGE DETERMINATIONS.—The Secretary shall develop
19 a plan to evaluate new local coverage determinations to
20 determine which determinations should be adopted na-
21 tionally and to what extent greater consistency can be
22 achieved among local coverage determinations.

23 “(B) CONSULTATION.—The Secretary shall re-
24 quire the fiscal intermediaries or carriers providing
25 services within the same area to consult on all new
26 local coverage determinations within the area.

27 “(C) DISSEMINATION OF INFORMATION.—The
28 Secretary should serve as a center to disseminate infor-
29 mation on local coverage determinations among fiscal
30 intermediaries and carriers to reduce duplication of ef-
31 fort.

32 “(6) NATIONAL AND LOCAL COVERAGE DETERMINA-
33 TION DEFINED.—For purposes of this subsection, the
34 terms ‘national coverage determination’ and ‘local coverage
35 determination’ have the meaning given such terms in para-
36 graphs (1)(B) and (2)(B), respectively, of section
37 1869(f).”.

1 (2) EFFECTIVE DATE.—The amendments made by
2 paragraph (1) shall apply to national and local coverage de-
3 terminations as of January 1, 2004.

4 (b) MEDICARE COVERAGE OF ROUTINE COSTS ASSOCI-
5 ATED WITH CERTAIN CLINICAL TRIALS.—

6 (1) IN GENERAL.—With respect to the coverage of
7 routine costs of care for beneficiaries participating in a
8 qualifying clinical trial, as set forth on the date of the en-
9 actment of this Act in National Coverage Determination
10 30-1 of the Medicare Coverage Issues Manual, the Sec-
11 retary shall deem clinical trials conducted in accordance
12 with an investigational device exemption approved under
13 section 520(g) of the Federal Food, Drug, and Cosmetic
14 Act (42 U.S.C. 360j(g)) to be automatically qualified for
15 such coverage.

16 (2) RULE OF CONSTRUCTION.—Nothing in this sub-
17 section shall be construed as authorizing or requiring the
18 Secretary to modify the regulations set forth on the date
19 of the enactment of this Act at subpart B of part 405 of
20 title 42, Code of Federal Regulations, or subpart A of part
21 411 of such title, relating to coverage of, and payment for,
22 a medical device that is the subject of an investigational de-
23 vice exemption by the Food and Drug Administration (ex-
24 cept as may be necessary to implement paragraph (1)).

25 (3) EFFECTIVE DATE.—This subsection shall apply to
26 clinical trials begun before, on, or after the date of the en-
27 actment of this Act and to items and services furnished on
28 or after such date.

29 (c) ISSUANCE OF TEMPORARY NATIONAL CODES.—Not
30 later than 1 year after the date of the enactment of this Act,
31 the Secretary shall implement revised procedures for the
32 issuance of temporary national HCPCS codes under part B of
33 title XVIII of the Social Security Act.

1 **SEC. 724. TREATMENT OF CERTAIN PHYSICIAN PATHOL-**
2 **OGY SERVICES.**

3 (a) IN GENERAL.—Section 1848(i) (42 U.S.C. 1395w–
4 4(i)) is amended by adding at the end the following new para-
5 graph:

6 “(4) TREATMENT OF CERTAIN INPATIENT PHYSICIAN
7 PATHOLOGY SERVICES.—

8 “(A) IN GENERAL.—With respect to services fur-
9 nished on or after January 1, 2001, if an independent
10 laboratory furnishes the technical component of a phy-
11 sician pathology service to a fee-for-service medicare
12 beneficiary who is an inpatient of a covered hospital,
13 the Secretary shall treat such component as a service
14 for which payment shall be made to the laboratory
15 under this section and not as an inpatient hospital
16 service for which payment is made to the hospital
17 under section 1886(d).

18 “(B) DEFINITIONS.—In this paragraph:

19 “(i) COVERED HOSPITAL.—

20 “(I) IN GENERAL.—The term ‘covered
21 hospital’ means, with respect to an inpatient or
22 outpatient, a hospital that had an arrangement
23 with an independent laboratory that was in ef-
24 fect as of July 22, 1999, under which a labora-
25 tory furnished the technical component of phy-
26 sician pathology services to fee-for-service
27 medicare beneficiaries who were hospital inpa-
28 tients or outpatients, respectively, and sub-
29 mitted claims for payment for such component
30 to a carrier with a contract under section 1842
31 and not to the hospital.

32 “(II) CHANGE IN OWNERSHIP DOES NOT
33 AFFECT DETERMINATION.—A change in owner-
34 ship with respect to a hospital on or after the
35 date referred to in subclause (I) shall not affect
36 the determination of whether such hospital is a
37 covered hospital for purposes of such subclause.

1 “(ii) FEE-FOR-SERVICE MEDICARE BENE-
2 FICIARY.—The term ‘fee-for-service medicare bene-
3 ficiary’ means an individual who is entitled to bene-
4 fits under part A, or enrolled under this part, or
5 both, but is not enrolled in any of the following:

6 “(I) A Medicare+Choice plan under part
7 C.

8 “(II) A plan offered by an eligible organi-
9 zation under section 1876.

10 “(III) A program of all-inclusive care for
11 the elderly (PACE) under section 1894.

12 “(IV) A social health maintenance organi-
13 zation (SHMO) demonstration project estab-
14 lished under section 4018(b) of the Omnibus
15 Budget Reconciliation Act of 1987 (Public Law
16 100–203).”.

17 (b) CONFORMING AMENDMENT.—Section 542 of the Medi-
18 care, Medicaid, and SCHIP Benefits Improvement and Protec-
19 tion Act of 2000 (114 Stat. 2763A–550), as enacted into law
20 by section 1(a)(6) of Public Law 106–554, is repealed.

21 (c) EFFECTIVE DATES.—The amendments made by this
22 section shall take effect as if included in the enactment of the
23 Medicare, Medicaid, and SCHIP Benefits Improvement and
24 Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463),
25 as enacted into law by section 1(a)(6) of Public Law 106–554.

26 **TITLE VIII—MEDICARE BENEFITS** 27 **ADMINISTRATION**

28 **SEC. 801. ESTABLISHMENT OF MEDICARE BENEFITS AD-** 29 **MINISTRATION.**

30 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.),
31 as amended by sections 105 and 721, is amended by inserting
32 after 1808 the following new section:

33 “MEDICARE BENEFITS ADMINISTRATION

34 “SEC. 1809. (a) ESTABLISHMENT.—There is established
35 within the Department of Health and Human Services an agen-
36 cy to be known as the Medicare Benefits Administration.

1 “(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF
2 ACTUARY.—

3 “(1) ADMINISTRATOR.—

4 “(A) IN GENERAL.—The Medicare Benefits Ad-
5 ministration shall be headed by an administrator to be
6 known as the ‘Medicare Benefits Administrator’ (in
7 this section referred to as the ‘Administrator’) who
8 shall be appointed by the President, by and with the
9 advice and consent of the Senate. The Administrator
10 shall be in direct line of authority to the Secretary.

11 “(B) COMPENSATION.—The Administrator shall
12 be paid at the rate of basic pay payable for level III
13 of the Executive Schedule under section 5314 of title
14 5, United States Code.

15 “(C) TERM OF OFFICE.—The Administrator shall
16 be appointed for a term of 5 years. In any case in
17 which a successor does not take office at the end of an
18 Administrator’s term of office, that Administrator may
19 continue in office until the entry upon office of such a
20 successor. An Administrator appointed to a term of of-
21 fice after the commencement of such term may serve
22 under such appointment only for the remainder of such
23 term.

24 “(D) GENERAL AUTHORITY.—The Administrator
25 shall be responsible for the exercise of all powers and
26 the discharge of all duties of the Administration, and
27 shall have authority and control over all personnel and
28 activities thereof.

29 “(E) RULEMAKING AUTHORITY.—The Adminis-
30 trator may prescribe such rules and regulations as the
31 Administrator determines necessary or appropriate to
32 carry out the functions of the Administration. The reg-
33 ulations prescribed by the Administrator shall be sub-
34 ject to the rulemaking procedures established under
35 section 553 of title 5, United States Code. The Admin-
36 istrator shall provide for the issuance of new regula-
37 tions to carry out parts C, D, and E.

1 “(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL
2 UNITS.—The Administrator may establish, alter, con-
3 solidate, or discontinue such organizational units or
4 components within the Administration as the Adminis-
5 trator considers necessary or appropriate, except as
6 specified in this section.

7 “(G) AUTHORITY TO DELEGATE.—The Adminis-
8 trator may assign duties, and delegate, or authorize
9 successive redelegations of, authority to act and to
10 render decisions, to such officers and employees of the
11 Administration as the Administrator may find nec-
12 essary. Within the limitations of such delegations, re-
13 delegations, or assignments, all official acts and deci-
14 sions of such officers and employees shall have the
15 same force and effect as though performed or rendered
16 by the Administrator.

17 “(2) DEPUTY ADMINISTRATOR.—

18 “(A) IN GENERAL.—There shall be a Deputy Ad-
19 ministrator of the Medicare Benefits Administration
20 who shall be appointed by the President, by and with
21 the advice and consent of the Senate.

22 “(B) COMPENSATION.—The Deputy Administrator
23 shall be paid at the rate of basic pay payable for level
24 IV of the Executive Schedule under section 5315 of
25 title 5, United States Code.

26 “(C) TERM OF OFFICE.—The Deputy Adminis-
27 trator shall be appointed for a term of 5 years. In any
28 case in which a successor does not take office at the
29 end of a Deputy Administrator’s term of office, such
30 Deputy Administrator may continue in office until the
31 entry upon office of such a successor. A Deputy Ad-
32 ministrator appointed to a term of office after the com-
33 mencement of such term may serve under such ap-
34 pointment only for the remainder of such term.

35 “(D) DUTIES.—The Deputy Administrator shall
36 perform such duties and exercise such powers as the
37 Administrator shall from time to time assign or dele-

1 gate. The Deputy Administrator shall be Acting Ad-
2 ministrator of the Administration during the absence or
3 disability of the Administrator and, unless the Presi-
4 dent designates another officer of the Government as
5 Acting Administrator, in the event of a vacancy in the
6 office of the Administrator.

7 “(3) CHIEF ACTUARY.—

8 “(A) IN GENERAL.—There is established in the
9 Administration the position of Chief Actuary. The
10 Chief Actuary shall be appointed by, and in direct line
11 of authority to, the Administrator of such Administra-
12 tion. The Chief Actuary shall be appointed from among
13 individuals who have demonstrated, by their education
14 and experience, superior expertise in the actuarial
15 sciences. The Chief Actuary may be removed only for
16 cause.

17 “(B) COMPENSATION.—The Chief Actuary shall
18 be compensated at the highest rate of basic pay for the
19 Senior Executive Service under section 5382(b) of title
20 5, United States Code.

21 “(C) DUTIES.—The Chief Actuary shall exercise
22 such duties as are appropriate for the office of the
23 Chief Actuary and in accordance with professional
24 standards of actuarial independence.

25 “(4) SECRETARIAL COORDINATION OF PROGRAM AD-
26 MINISTRATION.—The Secretary shall ensure appropriate
27 coordination between the Administrator and the Adminis-
28 trator of the Centers for Medicare & Medicaid Services in
29 carrying out the programs under this title.

30 “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

31 “(1) DUTIES.—

32 “(A) GENERAL DUTIES.—The Administrator shall
33 carry out parts C, D, and E, including—

34 “(i) negotiating, entering into, and enforcing,
35 contracts with plans for the offering of Medicare
36 Advantage plans under part C and EFFS plans

1 under part E, including the offering of qualified
2 prescription drug coverage under such plans; and

3 “(ii) negotiating, entering into, and enforcing,
4 contracts with PDP sponsors for the offering of
5 prescription drug plans under part D.

6 “(B) OTHER DUTIES.—The Administrator shall
7 carry out any duty provided for under part C, part D,
8 or part E, including demonstration projects carried out
9 in part or in whole under such parts, the programs of
10 all-inclusive care for the elderly (PACE program) under
11 section 1894, the social health maintenance organiza-
12 tion (SHMO) demonstration projects (referred to in
13 section 4104(c) of the Balanced Budget Act of 1997),
14 medicare cost contractors under section 1876(h), and
15 through a Medicare Advantage project that dem-
16 onstrates the application of capitation payment rates
17 for frail elderly medicare beneficiaries through the use
18 of a interdisciplinary team and through the provision of
19 primary care services to such beneficiaries by means of
20 such a team at the nursing facility involved).

21 “(C) PRESCRIPTION DRUG CARD.—The Adminis-
22 trator shall carry out section 1807 (relating to the
23 medicare prescription drug discount card endorsement
24 program).

25 “(D) NONINTERFERENCE.—In carrying out its
26 duties with respect to the provision of qualified pre-
27 scription drug coverage to beneficiaries under this title,
28 the Administrator may not—

29 “(i) require a particular formulary or institute
30 a price structure for the reimbursement of covered
31 outpatient drugs;

32 “(ii) interfere in any way with negotiations be-
33 tween PDP sponsors and Medicare Advantage or-
34 ganizations and EFFS organizations and drug
35 manufacturers, wholesalers, or other suppliers of
36 covered outpatient drugs; and

1 “(iii) otherwise interfere with the competitive
2 nature of providing such coverage through such
3 sponsors and organizations.

4 “(E) ANNUAL REPORTS.—Not later March 31 of
5 each year, the Administrator shall submit to Congress
6 and the President a report on the administration of
7 parts C, D, and E during the previous fiscal year.

8 “(2) STAFF.—

9 “(A) IN GENERAL.—The Administrator, with the
10 approval of the Secretary, may employ, without regard
11 to chapter 31 of title 5, United States Code, other than
12 sections 3110 and 3112, such officers and employees as
13 are necessary to administer the activities to be carried
14 out through the Medicare Benefits Administration. The
15 Administrator shall employ staff with appropriate and
16 necessary expertise in negotiating contracts in the pri-
17 vate sector.

18 “(B) FLEXIBILITY WITH RESPECT TO COMPENSA-
19 TION.—

20 “(i) IN GENERAL.—The staff of the Medicare
21 Benefits Administration shall, subject to clause (ii),
22 be paid without regard to the provisions of chapter
23 51 (other than section 5101) and chapter 53 (other
24 than section 5301) of such title (relating to classi-
25 fication and schedule pay rates).

26 “(ii) MAXIMUM RATE.—In no case may the
27 rate of compensation determined under clause (i)
28 exceed the rate of basic pay payable for level IV of
29 the Executive Schedule under section 5315 of title
30 5, United States Code.

31 “(C) LIMITATION ON FULL-TIME EQUIVALENT
32 STAFFING FOR CURRENT CMS FUNCTIONS BEING
33 TRANSFERRED.—The Administrator may not employ
34 under this paragraph a number of full-time equivalent
35 employees, to carry out functions that were previously
36 conducted by the Centers for Medicare & Medicaid
37 Services and that are conducted by the Administrator

1 by reason of this section, that exceeds the number of
2 such full-time equivalent employees authorized to be
3 employed by the Centers for Medicare & Medicaid Serv-
4 ices to conduct such functions as of the date of the en-
5 actment of this Act.

6 “(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE
7 CENTERS FOR MEDICARE & MEDICAID SERVICES.—

8 “(A) IN GENERAL.—The Secretary, the Adminis-
9 trator, and the Administrator of the Centers for Medi-
10 care & Medicaid Services shall establish an appropriate
11 transition of responsibility in order to redelegate the
12 administration of part C from the Secretary and the
13 Administrator of the Centers for Medicare & Medicaid
14 Services to the Administrator as is appropriate to carry
15 out the purposes of this section.

16 “(B) TRANSFER OF DATA AND INFORMATION.—
17 The Secretary shall ensure that the Administrator of
18 the Centers for Medicare & Medicaid Services transfers
19 to the Administrator of the Medicare Benefits Adminis-
20 tration such information and data in the possession of
21 the Administrator of the Centers for Medicare & Medi-
22 caid Services as the Administrator of the Medicare
23 Benefits Administration requires to carry out the du-
24 ties described in paragraph (1).

25 “(C) CONSTRUCTION.—Insofar as a responsibility
26 of the Secretary or the Administrator of the Centers
27 for Medicare & Medicaid Services is redelegated to the
28 Administrator under this section, any reference to the
29 Secretary or the Administrator of the Centers for Medi-
30 care & Medicaid Services in this title or title XI with
31 respect to such responsibility is deemed to be a ref-
32 erence to the Administrator.

33 “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

34 “(1) ESTABLISHMENT.—The Secretary shall establish
35 within the Medicare Benefits Administration an Office of
36 Beneficiary Assistance to coordinate functions relating to
37 outreach and education of medicare beneficiaries under this

1 title, including the functions described in paragraph (2).
2 The Office shall be separate operating division within the
3 Administration.

4 “(2) DISSEMINATION OF INFORMATION ON BENEFITS
5 AND APPEALS RIGHTS.—

6 “(A) DISSEMINATION OF BENEFITS INFORMA-
7 TION.—The Office of Beneficiary Assistance shall dis-
8 seminate, directly or through contract, to medicare
9 beneficiaries, by mail, by posting on the Internet site
10 of the Medicare Benefits Administration and through a
11 toll-free telephone number, information with respect to
12 the following:

13 “(i) Benefits, and limitations on payment (in-
14 cluding cost-sharing, stop-loss provisions, and for-
15 mulary restrictions) under parts C, D, and E.

16 “(ii) Benefits, and limitations on payment
17 under parts A and B, including information on
18 medicare supplemental policies under section 1882.
19 Such information shall be presented in a manner so
20 that medicare beneficiaries may compare benefits under
21 parts A, B, D, and medicare supplemental policies with
22 benefits under Medicare Advantage plans under part C
23 and EFFS plans under part E.

24 “(B) DISSEMINATION OF APPEALS RIGHTS INFOR-
25 MATION.—The Office of Beneficiary Assistance shall
26 disseminate to medicare beneficiaries in the manner
27 provided under subparagraph (A) a description of pro-
28 cedural rights (including grievance and appeals proce-
29 dures) of beneficiaries under the original medicare fee-
30 for-service program under parts A and B, the Medicare
31 Advantage program under part C, the Voluntary Pre-
32 scription Drug Benefit Program under part D, and the
33 Enhanced Fee-for-Service program under part E.

34 “(e) MEDICARE POLICY ADVISORY BOARD.—

35 “(1) ESTABLISHMENT.—There is established within
36 the Medicare Benefits Administration the Medicare Policy
37 Advisory Board (in this section referred to the ‘Board’).

1 The Board shall advise, consult with, and make rec-
2 ommendations to the Administrator of the Medicare Bene-
3 fits Administration with respect to the administration of
4 parts C, D, and E, including the review of payment policies
5 under such parts.

6 “(2) REPORTS.—

7 “(A) IN GENERAL.—With respect to matters of
8 the administration of parts C, D, and E the Board
9 shall submit to Congress and to the Administrator of
10 the Medicare Benefits Administration such reports as
11 the Board determines appropriate. Each such report
12 may contain such recommendations as the Board deter-
13 mines appropriate for legislative or administrative
14 changes to improve the administration of such parts,
15 including the topics described in subparagraph (B).
16 Each such report shall be published in the Federal
17 Register.

18 “(B) TOPICS DESCRIBED.—Reports required
19 under subparagraph (A) may include the following top-
20 ics:

21 “(i) FOSTERING COMPETITION.—Rec-
22 ommendations or proposals to increase competition
23 under parts C, D, and E for services furnished to
24 medicare beneficiaries.

25 “(ii) EDUCATION AND ENROLLMENT.—Rec-
26 ommendations for the improvement to efforts to
27 provide medicare beneficiaries information and edu-
28 cation on the program under this title, and specifi-
29 cally parts C, D, and E, and the program for en-
30 rollment under the title.

31 “(iii) IMPLEMENTATION OF RISK-ADJUST-
32 MENT.—Evaluation of the implementation under
33 section 1853(a)(3)(C) of the risk adjustment meth-
34 odology to payment rates under that section to
35 Medicare Advantage organizations offering Medi-
36 care Advantage plans (and the corresponding pay-
37 ment provisions under part E) that accounts for

1 variations in per capita costs based on health sta-
2 tus, geography, and other demographic factors.

3 “(iv) RURAL ACCESS.—Recommendations to
4 improve competition and access to plans under
5 parts C, D, and E in rural areas.

6 “(C) MAINTAINING INDEPENDENCE OF BOARD.—
7 The Board shall directly submit to Congress reports re-
8 quired under subparagraph (A). No officer or agency of
9 the United States may require the Board to submit to
10 any officer or agency of the United States for approval,
11 comments, or review, prior to the submission to Con-
12 gress of such reports.

13 “(3) DUTY OF ADMINISTRATOR OF MEDICARE BENE-
14 FITS ADMINISTRATION.—With respect to any report sub-
15 mitted by the Board under paragraph (2)(A), not later
16 than 90 days after the report is submitted, the Adminis-
17 trator of the Medicare Benefits Administration shall submit
18 to Congress and the President an analysis of recommenda-
19 tions made by the Board in such report. Each such analysis
20 shall be published in the Federal Register.

21 “(4) MEMBERSHIP.—

22 “(A) APPOINTMENT.—Subject to the succeeding
23 provisions of this paragraph, the Board shall consist of
24 seven members to be appointed as follows:

25 “(i) Three members shall be appointed by the
26 President.

27 “(ii) Two members shall be appointed by the
28 Speaker of the House of Representatives, with the
29 advice of the chairmen and the ranking minority
30 members of the Committees on Ways and Means
31 and on Energy and Commerce of the House of
32 Representatives.

33 “(iii) Two members shall be appointed by the
34 President pro tempore of the Senate with the ad-
35 vice of the chairman and the ranking minority
36 member of the Senate Committee on Finance.

1 “(B) QUALIFICATIONS.—The members shall be
2 chosen on the basis of their integrity, impartiality, and
3 good judgment, and shall be individuals who are, by
4 reason of their education and experience in health care
5 benefits management, exceptionally qualified to perform
6 the duties of members of the Board.

7 “(C) PROHIBITION ON INCLUSION OF FEDERAL
8 EMPLOYEES.—No officer or employee of the United
9 States may serve as a member of the Board.

10 “(5) COMPENSATION.—Members of the Board shall
11 receive, for each day (including travel time) they are en-
12 gaged in the performance of the functions of the board,
13 compensation at rates not to exceed the daily equivalent to
14 the annual rate in effect for level IV of the Executive
15 Schedule under section 5315 of title 5, United States Code.

16 “(6) TERMS OF OFFICE.—

17 “(A) IN GENERAL.—The term of office of mem-
18 bers of the Board shall be 3 years.

19 “(B) TERMS OF INITIAL APPOINTEES.—As des-
20 ignated by the President at the time of appointment,
21 of the members first appointed—

22 “(i) one shall be appointed for a term of 1
23 year;

24 “(ii) three shall be appointed for terms of 2
25 years; and

26 “(iii) three shall be appointed for terms of 3
27 years.

28 “(C) REAPPOINTMENTS.—Any person appointed
29 as a member of the Board may not serve for more than
30 8 years.

31 “(D) VACANCY.—Any member appointed to fill a
32 vacancy occurring before the expiration of the term for
33 which the member’s predecessor was appointed shall be
34 appointed only for the remainder of that term. A mem-
35 ber may serve after the expiration of that member’s
36 term until a successor has taken office. A vacancy in

1 the Board shall be filled in the manner in which the
2 original appointment was made.

3 “(7) CHAIR.—The Chair of the Board shall be elected
4 by the members. The term of office of the Chair shall be
5 3 years.

6 “(8) MEETINGS.—The Board shall meet at the call of
7 the Chair, but in no event less than three times during
8 each fiscal year.

9 “(9) DIRECTOR AND STAFF.—

10 “(A) APPOINTMENT OF DIRECTOR.—The Board
11 shall have a Director who shall be appointed by the
12 Chair.

13 “(B) IN GENERAL.—With the approval of the
14 Board, the Director may appoint, without regard to
15 chapter 31 of title 5, United States Code, such addi-
16 tional personnel as the Director considers appropriate.

17 “(C) FLEXIBILITY WITH RESPECT TO COMPENSA-
18 TION.—

19 “(i) IN GENERAL.—The Director and staff of
20 the Board shall, subject to clause (ii), be paid with-
21 out regard to the provisions of chapter 51 and
22 chapter 53 of such title (relating to classification
23 and schedule pay rates).

24 “(ii) MAXIMUM RATE.—In no case may the
25 rate of compensation determined under clause (i)
26 exceed the rate of basic pay payable for level IV of
27 the Executive Schedule under section 5315 of title
28 5, United States Code.

29 “(D) ASSISTANCE FROM THE ADMINISTRATOR OF
30 THE MEDICARE BENEFITS ADMINISTRATION.—The Ad-
31 ministrator of the Medicare Benefits Administration
32 shall make available to the Board such information and
33 other assistance as it may require to carry out its func-
34 tions.

35 “(10) CONTRACT AUTHORITY.—The Board may con-
36 tract with and compensate government and private agencies
37 or persons to carry out its duties under this subsection,

1 without regard to section 3709 of the Revised Statutes (41
2 U.S.C. 5).

3 “(f) FUNDING.—There is authorized to be appropriated, in
4 appropriate part from the Federal Hospital Insurance Trust
5 Fund and from the Federal Supplementary Medical Insurance
6 Trust Fund (including the Medicare Prescription Drug Ac-
7 count), such sums as are necessary to carry out this section.”.

8 (b) EFFECTIVE DATE.—

9 (1) IN GENERAL.—The amendment made by sub-
10 section (a) shall take effect on the date of the enactment
11 of this Act.

12 (2) DUTIES WITH RESPECT TO ELIGIBILITY DETER-
13 MINATIONS AND ENROLLMENT.—The Administrator of the
14 Medicare Benefits Administration shall carry out enroll-
15 ment under title XVIII of the Social Security Act, make
16 eligibility determinations under such title, and carry out
17 parts C and E of such title for years beginning or after
18 January 1, 2006.

19 (3) TRANSITION.—Before the date the Administrator
20 of the Medicare Benefits Administration is appointed and
21 assumes responsibilities under this section and section
22 1807 of the Social Security Act, the Secretary of Health
23 and Human Services shall provide for the conduct of any
24 responsibilities of such Administrator that are otherwise
25 provided under law.

26 (c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—

27 (1) ADMINISTRATOR AS MEMBER OF THE BOARD OF
28 TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section
29 1817(b) and section 1841(b) (42 U.S.C. 1395i(b),
30 1395t(b)) are each amended by striking “and the Secretary
31 of Health and Human Services, all ex officio,” and insert-
32 ing “the Secretary of Health and Human Services, and the
33 Administrator of the Medicare Benefits Administration, all
34 ex officio,”.

35 (2) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR
36 THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE &

1 MEDICAID SERVICES; LEVEL FOR MEDICARE BENEFITS AD-
2 MINISTRATOR.—

3 (A) IN GENERAL.—Section 5314 of title 5, United
4 States Code, by adding at the end the following:

5 “Administrator of the Centers for Medicare & Med-
6 icaid Services.

7 “Administrator of the Medicare Benefits Administra-
8 tion.”.

9 (B) CONFORMING AMENDMENT.—Section 5315 of
10 such title is amended by striking “Administrator of the
11 Health Care Financing Administration.”.

12 (C) EFFECTIVE DATE.—The amendments made by
13 this paragraph take effect on January 1, 2004.

14 **TITLE IX—REGULATORY REDUC-**
15 **TION AND CONTRACTING RE-**
16 **FORM**

17 **Subtitle A—Regulatory Reform**

18 **SEC. 901. CONSTRUCTION; DEFINITION OF SUPPLIER.**

19 (a) CONSTRUCTION.—Nothing in this title shall be
20 construed—

21 (1) to compromise or affect existing legal remedies for
22 addressing fraud or abuse, whether it be criminal prosecu-
23 tion, civil enforcement, or administrative remedies, includ-
24 ing under sections 3729 through 3733 of title 31, United
25 States Code (known as the False Claims Act); or

26 (2) to prevent or impede the Department of Health
27 and Human Services in any way from its ongoing efforts
28 to eliminate waste, fraud, and abuse in the medicare pro-
29 gram.

30 Furthermore, the consolidation of medicare administrative con-
31 tracting set forth in this Act does not constitute consolidation
32 of the Federal Hospital Insurance Trust Fund and the Federal
33 Supplementary Medical Insurance Trust Fund or reflect any
34 position on that issue.

1 (b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C.
2 1395x) is amended by inserting after subsection (c) the fol-
3 lowing new subsection:

4 “Supplier

5 “(d) The term ‘supplier’ means, unless the context other-
6 wise requires, a physician or other practitioner, a facility, or
7 other entity (other than a provider of services) that furnishes
8 items or services under this title.”.

9 **SEC. 902. ISSUANCE OF REGULATIONS.**

10 (a) REGULAR TIMELINE FOR PUBLICATION OF FINAL
11 RULES.—

12 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.
13 1395hh(a)) is amended by adding at the end the following
14 new paragraph:

15 “(3)(A) The Secretary, in consultation with the Director
16 of the Office of Management and Budget, shall establish and
17 publish a regular timeline for the publication of final regula-
18 tions based on the previous publication of a proposed regulation
19 or an interim final regulation.

20 “(B) Such timeline may vary among different regulations
21 based on differences in the complexity of the regulation, the
22 number and scope of comments received, and other relevant
23 factors, but shall not be longer than 3 years except under ex-
24 ceptional circumstances. If the Secretary intends to vary such
25 timeline with respect to the publication of a final regulation,
26 the Secretary shall cause to have published in the Federal Reg-
27 ister notice of the different timeline by not later than the
28 timeline previously established with respect to such regulation.
29 Such notice shall include a brief explanation of the justification
30 for such variation.

31 “(C) In the case of interim final regulations, upon the ex-
32 piration of the regular timeline established under this para-
33 graph for the publication of a final regulation after opportunity
34 for public comment, the interim final regulation shall not con-
35 tinue in effect unless the Secretary publishes (at the end of the
36 regular timeline and, if applicable, at the end of each suc-
37 ceeding 1-year period) a notice of continuation of the regulation

1 that includes an explanation of why the regular timeline (and
2 any subsequent 1-year extension) was not complied with. If
3 such a notice is published, the regular timeline (or such
4 timeline as previously extended under this paragraph) for publi-
5 cation of the final regulation shall be treated as having been
6 extended for 1 additional year.

7 “(D) The Secretary shall annually submit to Congress a
8 report that describes the instances in which the Secretary failed
9 to publish a final regulation within the applicable regular
10 timeline under this paragraph and that provides an explanation
11 for such failures.”.

12 (2) EFFECTIVE DATE.—The amendment made by
13 paragraph (1) shall take effect on the date of the enact-
14 ment of this Act. The Secretary shall provide for an appro-
15 priate transition to take into account the backlog of pre-
16 viously published interim final regulations.

17 (b) LIMITATIONS ON NEW MATTER IN FINAL REGULA-
18 TIONS.—

19 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.
20 1395hh(a)), as amended by subsection (a), is amended by
21 adding at the end the following new paragraph:

22 “(4) If the Secretary publishes a final regulation that in-
23 cludes a provision that is not a logical outgrowth of a pre-
24 viously published notice of proposed rulemaking or interim final
25 rule, such provision shall be treated as a proposed regulation
26 and shall not take effect until there is the further opportunity
27 for public comment and a publication of the provision again as
28 a final regulation.”.

29 (2) EFFECTIVE DATE.—The amendment made by
30 paragraph (1) shall apply to final regulations published on
31 or after the date of the enactment of this Act.

32 **SEC. 903. COMPLIANCE WITH CHANGES IN REGULA-**
33 **TIONS AND POLICIES.**

34 (a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE
35 CHANGES.—

1 (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh),
2 as amended by section 902(a), is amended by adding at the
3 end the following new subsection:

4 “(e)(1)(A) A substantive change in regulations, manual in-
5 structions, interpretative rules, statements of policy, or guide-
6 lines of general applicability under this title shall not be applied
7 (by extrapolation or otherwise) retroactively to items and serv-
8 ices furnished before the effective date of the change, unless
9 the Secretary determines that—

10 “(i) such retroactive application is necessary to comply
11 with statutory requirements; or

12 “(ii) failure to apply the change retroactively would be
13 contrary to the public interest.”.

14 (2) EFFECTIVE DATE.—The amendment made by
15 paragraph (1) shall apply to substantive changes issued on
16 or after the date of the enactment of this Act.

17 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE
18 CHANGES AFTER NOTICE.—

19 (1) IN GENERAL.—Section 1871(e)(1), as added by
20 subsection (a), is amended by adding at the end the fol-
21 lowing:

22 “(B)(i) Except as provided in clause (ii), a substantive
23 change referred to in subparagraph (A) shall not become effec-
24 tive before the end of the 30-day period that begins on the date
25 that the Secretary has issued or published, as the case may be,
26 the substantive change.

27 “(ii) The Secretary may provide for such a substantive
28 change to take effect on a date that precedes the end of the
29 30-day period under clause (i) if the Secretary finds that waiv-
30 er of such 30-day period is necessary to comply with statutory
31 requirements or that the application of such 30-day period is
32 contrary to the public interest. If the Secretary provides for an
33 earlier effective date pursuant to this clause, the Secretary
34 shall include in the issuance or publication of the substantive
35 change a finding described in the first sentence, and a brief
36 statement of the reasons for such finding.

1 “(C) No action shall be taken against a provider of serv-
2 ices or supplier with respect to noncompliance with such a sub-
3 stantive change for items and services furnished before the ef-
4 fective date of such a change.”.

5 (2) EFFECTIVE DATE.—The amendment made by
6 paragraph (1) shall apply to compliance actions undertaken
7 on or after the date of the enactment of this Act.

8 (c) RELIANCE ON GUIDANCE.—

9 (1) IN GENERAL.—Section 1871(e), as added by sub-
10 section (a), is further amended by adding at the end the
11 following new paragraph:

12 “(2)(A) If—

13 “(i) a provider of services or supplier follows the writ-
14 ten guidance (which may be transmitted electronically) pro-
15 vided by the Secretary or by a medicare contractor (as de-
16 fined in section 1889(g)) acting within the scope of the
17 contractor’s contract authority, with respect to the fur-
18 nishing of items or services and submission of a claim for
19 benefits for such items or services with respect to such pro-
20 vider or supplier;

21 “(ii) the Secretary determines that the provider of
22 services or supplier has accurately presented the cir-
23 cumstances relating to such items, services, and claim to
24 the contractor in writing; and

25 “(iii) the guidance was in error;

26 the provider of services or supplier shall not be subject to any
27 sanction (including any penalty or requirement for repayment
28 of any amount) if the provider of services or supplier reason-
29 ably relied on such guidance.

30 “(B) Subparagraph (A) shall not be construed as pre-
31 venting the recoupment or repayment (without any additional
32 penalty) relating to an overpayment insofar as the overpayment
33 was solely the result of a clerical or technical operational
34 error.”.

35 (2) EFFECTIVE DATE.—The amendment made by
36 paragraph (1) shall take effect on the date of the enact-
37 ment of this Act but shall not apply to any sanction for

1 which notice was provided on or before the date of the en-
2 actment of this Act.

3 **SEC. 904. REPORTS AND STUDIES RELATING TO REGU-**
4 **LATORY REFORM.**

5 (a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

6 (1) STUDY.—The Comptroller General of the United
7 States shall conduct a study to determine the feasibility
8 and appropriateness of establishing in the Secretary au-
9 thority to provide legally binding advisory opinions on ap-
10 propriate interpretation and application of regulations to
11 carry out the medicare program under title XVIII of the
12 Social Security Act. Such study shall examine the appro-
13 priate timeframe for issuing such advisory opinions, as well
14 as the need for additional staff and funding to provide such
15 opinions.

16 (2) REPORT.—The Comptroller General shall submit
17 to Congress a report on the study conducted under para-
18 graph (1) by not later than one year after the date of the
19 enactment of this Act.

20 (b) REPORT ON LEGAL AND REGULATORY INCONSIST-
21 ENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by
22 section 2(a), is amended by adding at the end the following new
23 subsection:

24 “(f)(1) Not later than 2 years after the date of the enact-
25 ment of this subsection, and every 2 years thereafter, the Sec-
26 retary shall submit to Congress a report with respect to the ad-
27 ministration of this title and areas of inconsistency or conflict
28 among the various provisions under law and regulation.

29 “(2) In preparing a report under paragraph (1), the Sec-
30 retary shall collect—

31 “(A) information from individuals entitled to benefits
32 under part A or enrolled under part B, or both, providers
33 of services, and suppliers and from the Medicare Bene-
34 ficiary Ombudsman and the Medicare Provider Ombuds-
35 man with respect to such areas of inconsistency and con-
36 flict; and

1 “(B) information from medicare contractors that
2 tracks the nature of written and telephone inquiries.

3 “(3) A report under paragraph (1) shall include a descrip-
4 tion of efforts by the Secretary to reduce such inconsistency or
5 conflicts, and recommendations for legislation or administrative
6 action that the Secretary determines appropriate to further re-
7 duce such inconsistency or conflicts.”.

8 **Subtitle B—Contracting Reform**

9 **SEC. 911. INCREASED FLEXIBILITY IN MEDICARE AD-** 10 **MINISTRATION.**

11 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE AD-
12 MINISTRATION.—

13 (1) IN GENERAL.—Title XVIII is amended by insert-
14 ing after section 1874 the following new section:

15 “CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

16 “SEC. 1874A. (a) AUTHORITY.—

17 “(1) AUTHORITY TO ENTER INTO CONTRACTS.—The
18 Secretary may enter into contracts with any eligible entity
19 to serve as a medicare administrative contractor with re-
20 spect to the performance of any or all of the functions de-
21 scribed in paragraph (4) or parts of those functions (or, to
22 the extent provided in a contract, to secure performance
23 thereof by other entities).

24 “(2) ELIGIBILITY OF ENTITIES.—An entity is eligible
25 to enter into a contract with respect to the performance of
26 a particular function described in paragraph (4) only if—

27 “(A) the entity has demonstrated capability to
28 carry out such function;

29 “(B) the entity complies with such conflict of in-
30 terest standards as are generally applicable to Federal
31 acquisition and procurement;

32 “(C) the entity has sufficient assets to financially
33 support the performance of such function; and

34 “(D) the entity meets such other requirements as
35 the Secretary may impose.

36 “(3) MEDICARE ADMINISTRATIVE CONTRACTOR DE-
37 FINED.—For purposes of this title and title XI—

1 “(A) IN GENERAL.—The term ‘medicare adminis-
2 trative contractor’ means an agency, organization, or
3 other person with a contract under this section.

4 “(B) APPROPRIATE MEDICARE ADMINISTRATIVE
5 CONTRACTOR.—With respect to the performance of a
6 particular function in relation to an individual entitled
7 to benefits under part A or enrolled under part B, or
8 both, a specific provider of services or supplier (or class
9 of such providers of services or suppliers), the ‘appro-
10 priate’ medicare administrative contractor is the medi-
11 care administrative contractor that has a contract
12 under this section with respect to the performance of
13 that function in relation to that individual, provider of
14 services or supplier or class of provider of services or
15 supplier.

16 “(4) FUNCTIONS DESCRIBED.—The functions referred
17 to in paragraphs (1) and (2) are payment functions, pro-
18 vider services functions, and functions relating to services
19 furnished to individuals entitled to benefits under part A
20 or enrolled under part B, or both, as follows:

21 “(A) DETERMINATION OF PAYMENT AMOUNTS.—
22 Determining (subject to the provisions of section 1878
23 and to such review by the Secretary as may be provided
24 for by the contracts) the amount of the payments re-
25 quired pursuant to this title to be made to providers of
26 services, suppliers and individuals.

27 “(B) MAKING PAYMENTS.—Making payments de-
28 scribed in subparagraph (A) (including receipt, dis-
29 bursement, and accounting for funds in making such
30 payments).

31 “(C) BENEFICIARY EDUCATION AND ASSIST-
32 ANCE.—Providing education and outreach to individ-
33 uals entitled to benefits under part A or enrolled under
34 part B, or both, and providing assistance to those indi-
35 viduals with specific issues, concerns or problems.

36 “(D) PROVIDER CONSULTATIVE SERVICES.—Pro-
37 viding consultative services to institutions, agencies,

1 and other persons to enable them to establish and
2 maintain fiscal records necessary for purposes of this
3 title and otherwise to qualify as providers of services or
4 suppliers.

5 “(E) COMMUNICATION WITH PROVIDERS.—Com-
6 municating to providers of services and suppliers any
7 information or instructions furnished to the medicare
8 administrative contractor by the Secretary, and facili-
9 tating communication between such providers and sup-
10 pliers and the Secretary.

11 “(F) PROVIDER EDUCATION AND TECHNICAL AS-
12 SISTANCE.—Performing the functions relating to pro-
13 vider education, training, and technical assistance.

14 “(G) ADDITIONAL FUNCTIONS.—Performing such
15 other functions as are necessary to carry out the pur-
16 poses of this title.

17 “(5) RELATIONSHIP TO MIP CONTRACTS.—

18 “(A) NONDUPLICATION OF DUTIES.—In entering
19 into contracts under this section, the Secretary shall
20 assure that functions of medicare administrative con-
21 tractors in carrying out activities under parts A and B
22 do not duplicate activities carried out under the Medi-
23 care Integrity Program under section 1893. The pre-
24 vious sentence shall not apply with respect to the activ-
25 ity described in section 1893(b)(5) (relating to prior
26 authorization of certain items of durable medical equip-
27 ment under section 1834(a)(15)).

28 “(B) CONSTRUCTION.—An entity shall not be
29 treated as a medicare administrative contractor merely
30 by reason of having entered into a contract with the
31 Secretary under section 1893.

32 “(6) APPLICATION OF FEDERAL ACQUISITION REGULA-
33 TION.—Except to the extent inconsistent with a specific re-
34 quirement of this title, the Federal Acquisition Regulation
35 applies to contracts under this title.

36 “(b) CONTRACTING REQUIREMENTS.—

37 “(1) USE OF COMPETITIVE PROCEDURES.—

1 “(A) IN GENERAL.—Except as provided in laws
2 with general applicability to Federal acquisition and
3 procurement or in subparagraph (B), the Secretary
4 shall use competitive procedures when entering into
5 contracts with medicare administrative contractors
6 under this section, taking into account performance
7 quality as well as price and other factors.

8 “(B) RENEWAL OF CONTRACTS.—The Secretary
9 may renew a contract with a medicare administrative
10 contractor under this section from term to term with-
11 out regard to section 5 of title 41, United States Code,
12 or any other provision of law requiring competition, if
13 the medicare administrative contractor has met or ex-
14 ceeded the performance requirements applicable with
15 respect to the contract and contractor, except that the
16 Secretary shall provide for the application of competi-
17 tive procedures under such a contract not less fre-
18 quently than once every five years.

19 “(C) TRANSFER OF FUNCTIONS.—The Secretary
20 may transfer functions among medicare administrative
21 contractors consistent with the provisions of this para-
22 graph. The Secretary shall ensure that performance
23 quality is considered in such transfers. The Secretary
24 shall provide public notice (whether in the Federal Reg-
25 ister or otherwise) of any such transfer (including a de-
26 scription of the functions so transferred, a description
27 of the providers of services and suppliers affected by
28 such transfer, and contact information for the contrac-
29 tors involved).

30 “(D) INCENTIVES FOR QUALITY.—The Secretary
31 shall provide incentives for medicare administrative
32 contractors to provide quality service and to promote
33 efficiency.

34 “(2) COMPLIANCE WITH REQUIREMENTS.—No con-
35 tract under this section shall be entered into with any
36 medicare administrative contractor unless the Secretary
37 finds that such medicare administrative contractor will per-

1 form its obligations under the contract efficiently and effec-
2 tively and will meet such requirements as to financial re-
3 sponsibility, legal authority, quality of services provided,
4 and other matters as the Secretary finds pertinent.

5 “(3) PERFORMANCE REQUIREMENTS.—

6 “(A) DEVELOPMENT OF SPECIFIC PERFORMANCE
7 REQUIREMENTS.—In developing contract performance
8 requirements, the Secretary shall develop performance
9 requirements applicable to functions described in sub-
10 section (a)(4).

11 “(B) CONSULTATION.— In developing such re-
12 quirements, the Secretary may consult with providers
13 of services and suppliers, organizations representing in-
14 dividuals entitled to benefits under part A or enrolled
15 under part B, or both, and organizations and agencies
16 performing functions necessary to carry out the pur-
17 poses of this section with respect to such performance
18 requirements.

19 “(C) INCLUSION IN CONTRACTS.—All contractor
20 performance requirements shall be set forth in the con-
21 tract between the Secretary and the appropriate medi-
22 care administrative contractor. Such performance
23 requirements—

24 “(i) shall reflect the performance requirements
25 developed under subparagraph (A), but may in-
26 clude additional performance requirements;

27 “(ii) shall be used for evaluating contractor
28 performance under the contract; and

29 “(iii) shall be consistent with the written state-
30 ment of work provided under the contract.

31 “(4) INFORMATION REQUIREMENTS.—The Secretary
32 shall not enter into a contract with a medicare administra-
33 tive contractor under this section unless the contractor
34 agrees—

35 “(A) to furnish to the Secretary such timely infor-
36 mation and reports as the Secretary may find nec-
37 essary in performing his functions under this title; and

1 “(B) to maintain such records and afford such ac-
2 cess thereto as the Secretary finds necessary to assure
3 the correctness and verification of the information and
4 reports under subparagraph (A) and otherwise to carry
5 out the purposes of this title.

6 “(5) SURETY BOND.—A contract with a medicare ad-
7 ministrative contractor under this section may require the
8 medicare administrative contractor, and any of its officers
9 or employees certifying payments or disbursing funds pur-
10 suant to the contract, or otherwise participating in carrying
11 out the contract, to give surety bond to the United States
12 in such amount as the Secretary may deem appropriate.

13 “(c) TERMS AND CONDITIONS.—

14 “(1) IN GENERAL.—A contract with any medicare ad-
15 ministrative contractor under this section may contain such
16 terms and conditions as the Secretary finds necessary or
17 appropriate and may provide for advances of funds to the
18 medicare administrative contractor for the making of pay-
19 ments by it under subsection (a)(4)(B).

20 “(2) PROHIBITION ON MANDATES FOR CERTAIN DATA
21 COLLECTION.—The Secretary may not require, as a condi-
22 tion of entering into, or renewing, a contract under this
23 section, that the medicare administrative contractor match
24 data obtained other than in its activities under this title
25 with data used in the administration of this title for pur-
26 poses of identifying situations in which the provisions of
27 section 1862(b) may apply.

28 “(d) LIMITATION ON LIABILITY OF MEDICARE ADMINIS-
29 TRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

30 “(1) CERTIFYING OFFICER.—No individual designated
31 pursuant to a contract under this section as a certifying of-
32 ficer shall, in the absence of the reckless disregard of the
33 individual’s obligations or the intent by that individual to
34 defraud the United States, be liable with respect to any
35 payments certified by the individual under this section.

36 “(2) DISBURSING OFFICER.—No disbursing officer
37 shall, in the absence of the reckless disregard of the offi-

cer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

“(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

“(A) IN GENERAL.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

“(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the ‘False Claims Act’).

“(4) INDEMNIFICATION BY SECRETARY.—

“(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

“(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct

1 that is determined by the judicial proceeding or by the
2 Secretary to be criminal in nature, fraudulent, or
3 grossly negligent. If indemnification is provided by the
4 Secretary with respect to a contractor before a deter-
5 mination that such costs arose directly from such con-
6 duct, the contractor shall reimburse the Secretary for
7 costs of indemnification.

8 “(C) SCOPE OF INDEMNIFICATION.—Indemnifica-
9 tion by the Secretary under subparagraph (A) may in-
10 clude payment of judgments, settlements (subject to
11 subparagraph (D)), awards, and costs (including rea-
12 sonable legal expenses).

13 “(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A
14 contractor or other person described in subparagraph
15 (A) may not propose to negotiate a settlement or com-
16 promise of a proceeding described in such subpara-
17 graph without the prior written approval of the Sec-
18 retary to negotiate such settlement or compromise. Any
19 indemnification under subparagraph (A) with respect to
20 amounts paid under a settlement or compromise of a
21 proceeding described in such subparagraph are condi-
22 tioned upon prior written approval by the Secretary of
23 the final settlement or compromise.

24 “(E) CONSTRUCTION.—Nothing in this paragraph
25 shall be construed—

26 “(i) to change any common law immunity that
27 may be available to a medicare administrative con-
28 tractor or person described in subparagraph (A); or

29 “(ii) to permit the payment of costs not other-
30 wise allowable, reasonable, or allocable under the
31 Federal Acquisition Regulations.”.

32 (2) CONSIDERATION OF INCORPORATION OF CURRENT
33 LAW STANDARDS.—In developing contract performance re-
34 quirements under section 1874A(b) of the Social Security
35 Act, as inserted by paragraph (1), the Secretary shall con-
36 sider inclusion of the performance standards described in
37 sections 1816(f)(2) of such Act (relating to timely proc-

1 essing of reconsiderations and applications for exemptions)
2 and section 1842(b)(2)(B) of such Act (relating to timely
3 review of determinations and fair hearing requests), as
4 such sections were in effect before the date of the enact-
5 ment of this Act.

6 (b) CONFORMING AMENDMENTS TO SECTION 1816 (RE-
7 LATING TO FISCAL INTERMEDIARIES).—Section 1816 (42
8 U.S.C. 1395h) is amended as follows:

9 (1) The heading is amended to read as follows:
10 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART A”.

11 (2) Subsection (a) is amended to read as follows:

12 “(a) The administration of this part shall be conducted
13 through contracts with medicare administrative contractors
14 under section 1874A.”.

15 (3) Subsection (b) is repealed.

16 (4) Subsection (c) is amended—

17 (A) by striking paragraph (1); and

18 (B) in each of paragraphs (2)(A) and (3)(A), by
19 striking “agreement under this section” and inserting
20 “contract under section 1874A that provides for mak-
21 ing payments under this part”.

22 (5) Subsections (d) through (i) are repealed.

23 (6) Subsections (j) and (k) are each amended—

24 (A) by striking “An agreement with an agency or
25 organization under this section” and inserting “A con-
26 tract with a medicare administrative contractor under
27 section 1874A with respect to the administration of
28 this part”; and

29 (B) by striking “such agency or organization” and
30 inserting “such medicare administrative contractor”
31 each place it appears.

32 (7) Subsection (l) is repealed.

33 (c) CONFORMING AMENDMENTS TO SECTION 1842 (RE-
34 LATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is
35 amended as follows:

36 (1) The heading is amended to read as follows:

1 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART B”.

2 (2) Subsection (a) is amended to read as follows:

3 “(a) The administration of this part shall be conducted
4 through contracts with medicare administrative contractors
5 under section 1874A.”.

6 (3) Subsection (b) is amended—

7 (A) by striking paragraph (1);

8 (B) in paragraph (2)—

9 (i) by striking subparagraphs (A) and (B);

10 (ii) in subparagraph (C), by striking “car-
11 riers” and inserting “medicare administrative con-
12 tractors”; and

13 (iii) by striking subparagraphs (D) and (E);

14 (C) in paragraph (3)—

15 (i) in the matter before subparagraph (A), by
16 striking “Each such contract shall provide that the
17 carrier” and inserting “The Secretary”;

18 (ii) by striking “will” the first place it appears
19 in each of subparagraphs (A), (B), (F), (G), (H),
20 and (L) and inserting “shall”;

21 (iii) in subparagraph (B), in the matter before
22 clause (i), by striking “to the policyholders and
23 subscribers of the carrier” and inserting “to the
24 policyholders and subscribers of the medicare ad-
25 ministrative contractor”;

26 (iv) by striking subparagraphs (C), (D), and
27 (E);

28 (v) in subparagraph (H)—

29 (I) by striking “if it makes determinations
30 or payments with respect to physicians’ serv-
31 ices,” in the matter preceding clause (i); and

32 (II) by striking “carrier” and inserting
33 “medicare administrative contractor” in clause
34 (i);

35 (vi) by striking subparagraph (I);

36 (vii) in subparagraph (L), by striking the
37 semicolon and inserting a period;

1 (viii) in the first sentence, after subparagraph
2 (L), by striking “and shall contain” and all that
3 follows through the period; and

4 (ix) in the seventh sentence, by inserting
5 “medicare administrative contractor,” after “car-
6 rier,”; and

7 (D) by striking paragraph (5);

8 (E) in paragraph (6)(D)(iv), by striking “carrier”
9 and inserting “medicare administrative contractor”;
10 and

11 (F) in paragraph (7), by striking “the carrier”
12 and inserting “the Secretary” each place it appears.

13 (4) Subsection (c) is amended—

14 (A) by striking paragraph (1);

15 (B) in paragraph (2)(A), by striking “contract
16 under this section which provides for the disbursement
17 of funds, as described in subsection (a)(1)(B),” and in-
18 serting “contract under section 1874A that provides for
19 making payments under this part”;

20 (C) in paragraph (3)(A), by striking “subsection
21 (a)(1)(B)” and inserting “section 1874A(a)(3)(B)”;

22 (D) in paragraph (4), in the matter preceding sub-
23 paragraph (A), by striking “carrier” and inserting
24 “medicare administrative contractor”; and

25 (E) by striking paragraphs (5) and (6).

26 (5) Subsections (d), (e), and (f) are repealed.

27 (6) Subsection (g) is amended by striking “carrier or
28 carriers” and inserting “medicare administrative contractor
29 or contractors”.

30 (7) Subsection (h) is amended—

31 (A) in paragraph (2)—

32 (i) by striking “Each carrier having an agree-
33 ment with the Secretary under subsection (a)” and
34 inserting “The Secretary”; and

35 (ii) by striking “Each such carrier” and in-
36 serting “The Secretary”;

37 (B) in paragraph (3)(A)—

1 (i) by striking “a carrier having an agreement
2 with the Secretary under subsection (a)” and in-
3 serting “medicare administrative contractor having
4 a contract under section 1874A that provides for
5 making payments under this part”; and

6 (ii) by striking “such carrier” and inserting
7 “such contractor”;

8 (C) in paragraph (3)(B)—

9 (i) by striking “a carrier” and inserting “a
10 medicare administrative contractor” each place it
11 appears; and

12 (ii) by striking “the carrier” and inserting
13 “the contractor” each place it appears; and

14 (D) in paragraphs (5)(A) and (5)(B)(iii), by strik-
15 ing “carriers” and inserting “medicare administrative
16 contractors” each place it appears.

17 (8) Subsection (l) is amended—

18 (A) in paragraph (1)(A)(iii), by striking “carrier”
19 and inserting “medicare administrative contractor”;
20 and

21 (B) in paragraph (2), by striking “carrier” and in-
22 serting “medicare administrative contractor”.

23 (9) Subsection (p)(3)(A) is amended by striking “car-
24 rier” and inserting “medicare administrative contractor”.

25 (10) Subsection (q)(1)(A) is amended by striking “car-
26 rier”.

27 (d) EFFECTIVE DATE; TRANSITION RULE.—

28 (1) EFFECTIVE DATE.—

29 (A) IN GENERAL.—Except as otherwise provided
30 in this subsection, the amendments made by this sec-
31 tion shall take effect on October 1, 2005, and the Sec-
32 retary is authorized to take such steps before such date
33 as may be necessary to implement such amendments on
34 a timely basis.

35 (B) CONSTRUCTION FOR CURRENT CONTRACTS.—
36 Such amendments shall not apply to contracts in effect
37 before the date specified under subparagraph (A) that

1 continue to retain the terms and conditions in effect on
2 such date (except as otherwise provided under this Act,
3 other than under this section) until such date as the
4 contract is let out for competitive bidding under such
5 amendments.

6 (C) DEADLINE FOR COMPETITIVE BIDDING.—The
7 Secretary shall provide for the letting by competitive
8 bidding of all contracts for functions of medicare ad-
9 ministrative contractors for annual contract periods
10 that begin on or after October 1, 2010.

11 (D) WAIVER OF PROVIDER NOMINATION PROVI-
12 SIONS DURING TRANSITION.—During the period begin-
13 ning on the date of the enactment of this Act and be-
14 fore the date specified under subparagraph (A), the
15 Secretary may enter into new agreements under section
16 1816 of the Social Security Act (42 U.S.C. 1395h)
17 without regard to any of the provider nomination provi-
18 sions of such section.

19 (2) GENERAL TRANSITION RULES.—The Secretary
20 shall take such steps, consistent with paragraph (1)(B) and
21 (1)(C), as are necessary to provide for an appropriate tran-
22 sition from contracts under section 1816 and section 1842
23 of the Social Security Act (42 U.S.C. 1395h, 1395u) to
24 contracts under section 1874A, as added by subsection
25 (a)(1).

26 (3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS
27 UNDER CURRENT CONTRACTS AND AGREEMENTS AND
28 UNDER ROLLOVER CONTRACTS.—The provisions contained
29 in the exception in section 1893(d)(2) of the Social Secu-
30 rity Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply
31 notwithstanding the amendments made by this section, and
32 any reference in such provisions to an agreement or con-
33 tract shall be deemed to include a contract under section
34 1874A of such Act, as inserted by subsection (a)(1), that
35 continues the activities referred to in such provisions.

36 (e) REFERENCES.—On and after the effective date pro-
37 vided under subsection (d)(1), any reference to a fiscal inter-

1 mediary or carrier under title XI or XVIII of the Social Secu-
2 rity Act (or any regulation, manual instruction, interpretative
3 rule, statement of policy, or guideline issued to carry out such
4 titles) shall be deemed a reference to a medicare administrative
5 contractor (as provided under section 1874A of the Social Se-
6 curity Act).

7 (f) REPORTS ON IMPLEMENTATION.—

8 (1) PLAN FOR IMPLEMENTATION.—By not later than
9 October 1, 2004, the Secretary shall submit a report to
10 Congress and the Comptroller General of the United States
11 that describes the plan for implementation of the amend-
12 ments made by this section. The Comptroller General shall
13 conduct an evaluation of such plan and shall submit to
14 Congress, not later than 6 months after the date the report
15 is received, a report on such evaluation and shall include
16 in such report such recommendations as the Comptroller
17 General deems appropriate.

18 (2) STATUS OF IMPLEMENTATION.—The Secretary
19 shall submit a report to Congress not later than October
20 1, 2008, that describes the status of implementation of
21 such amendments and that includes a description of the
22 following:

23 (A) The number of contracts that have been com-
24 petitively bid as of such date.

25 (B) The distribution of functions among contracts
26 and contractors.

27 (C) A timeline for complete transition to full com-
28 petition.

29 (D) A detailed description of how the Secretary
30 has modified oversight and management of medicare
31 contractors to adapt to full competition.

32 **SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY**
33 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**
34 **TORS.**

35 (a) IN GENERAL.—Section 1874A, as added by section
36 911(a)(1), is amended by adding at the end the following new
37 subsection:

1 “(e) REQUIREMENTS FOR INFORMATION SECURITY.—

2 “(1) DEVELOPMENT OF INFORMATION SECURITY PRO-
3 GRAM.—A medicare administrative contractor that per-
4 forms the functions referred to in subparagraphs (A) and
5 (B) of subsection (a)(4) (relating to determining and mak-
6 ing payments) shall implement a contractor-wide informa-
7 tion security program to provide information security for
8 the operation and assets of the contractor with respect to
9 such functions under this title. An information security
10 program under this paragraph shall meet the requirements
11 for information security programs imposed on Federal
12 agencies under paragraphs (1) through (8) of section
13 3544(b) of title 44, United States Code (other than the re-
14 quirements under paragraphs (2)(D)(i), (5)(A), and (5)(B)
15 of such section).

16 “(2) INDEPENDENT AUDITS.—

17 “(A) PERFORMANCE OF ANNUAL EVALUATIONS.—
18 Each year a medicare administrative contractor that
19 performs the functions referred to in subparagraphs
20 (A) and (B) of subsection (a)(4) (relating to deter-
21 mining and making payments) shall undergo an evalua-
22 tion of the information security of the contractor with
23 respect to such functions under this title. The evalua-
24 tion shall—

25 “(i) be performed by an entity that meets such
26 requirements for independence as the Inspector
27 General of the Department of Health and Human
28 Services may establish; and

29 “(ii) test the effectiveness of information secu-
30 rity control techniques of an appropriate subset of
31 the contractor’s information systems (as defined in
32 section 3502(8) of title 44, United States Code) re-
33 lating to such functions under this title and an as-
34 sessment of compliance with the requirements of
35 this subsection and related information security
36 policies, procedures, standards and guidelines, in-
37 cluding policies and procedures as may be pre-

scribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

“(B) DEADLINE FOR INITIAL EVALUATION.—

“(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

“(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

“(C) REPORTS ON EVALUATIONS.—

“(i) TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

“(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

“(iii) AGENCY REPORTING.—The Secretary shall address the results of such evaluations in re-

ports required under section 3544(c) of title 44,
United States Code.”.

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTER-
MEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 921. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

“PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

“SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

1 (3) REPORT.—Not later than October 1, 2004, the
2 Secretary shall submit to Congress a report that includes
3 a description and evaluation of the steps taken to coordi-
4 nate the funding of provider education under section
5 1889(a) of the Social Security Act, as added by paragraph
6 (1).

7 (b) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-
8 ANCE.—

9 (1) IN GENERAL.—Section 1874A, as added by section
10 911(a)(1) and as amended by section 912(a), is amended
11 by adding at the end the following new subsection:

12 “(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-
13 ANCE IN PROVIDER EDUCATION AND OUTREACH.—The Sec-
14 retary shall use specific claims payment error rates or similar
15 methodology of medicare administrative contractors in the
16 processing or reviewing of medicare claims in order to give such
17 contractors an incentive to implement effective education and
18 outreach programs for providers of services and suppliers.”.

19 (2) APPLICATION TO FISCAL INTERMEDIARIES AND
20 CARRIERS.—The provisions of section 1874A(f) of the So-
21 cial Security Act, as added by paragraph (1), shall apply
22 to each fiscal intermediary under section 1816 of the Social
23 Security Act (42 U.S.C. 1395h) and each carrier under
24 section 1842 of such Act (42 U.S.C. 1395u) in the same
25 manner as they apply to medicare administrative contrac-
26 tors under such provisions.

27 (3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—
28 Not later than October 1, 2004, the Comptroller General
29 of the United States shall submit to Congress and to the
30 Secretary a report on the adequacy of the methodology
31 under section 1874A(f) of the Social Security Act, as added
32 by paragraph (1), and shall include in the report such rec-
33 ommendations as the Comptroller General determines ap-
34 propriate with respect to the methodology.

35 (4) REPORT ON USE OF METHODOLOGY IN ASSESSING
36 CONTRACTOR PERFORMANCE.—Not later than October 1,
37 2004, the Secretary shall submit to Congress a report that

1 describes how the Secretary intends to use such method-
2 ology in assessing medicare contractor performance in im-
3 plementing effective education and outreach programs, in-
4 cluding whether to use such methodology as a basis for per-
5 formance bonuses. The report shall include an analysis of
6 the sources of identified errors and potential changes in
7 systems of contractors and rules of the Secretary that could
8 reduce claims error rates.

9 (c) PROVISION OF ACCESS TO AND PROMPT RESPONSES
10 FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

11 (1) IN GENERAL.—Section 1874A, as added by section
12 911(a)(1) and as amended by section 912(a) and sub-
13 section (b), is further amended by adding at the end the
14 following new subsection:

15 “(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS
16 OF SERVICES AND SUPPLIERS.—

17 “(1) COMMUNICATION STRATEGY.—The Secretary
18 shall develop a strategy for communications with individ-
19 uals entitled to benefits under part A or enrolled under
20 part B, or both, and with providers of services and sup-
21 pliers under this title.

22 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each medi-
23 care administrative contractor shall, for those providers of
24 services and suppliers which submit claims to the con-
25 tractor for claims processing and for those individuals enti-
26 tled to benefits under part A or enrolled under part B, or
27 both, with respect to whom claims are submitted for claims
28 processing, provide general written responses (which may
29 be through electronic transmission) in a clear, concise, and
30 accurate manner to inquiries of providers of services, sup-
31 pliers and individuals entitled to benefits under part A or
32 enrolled under part B, or both, concerning the programs
33 under this title within 45 business days of the date of re-
34 ceipt of such inquiries.

35 “(3) RESPONSE TO TOLL-FREE LINES.—The Secretary
36 shall ensure that each medicare administrative contractor
37 shall provide, for those providers of services and suppliers

1 which submit claims to the contractor for claims processing
2 and for those individuals entitled to benefits under part A
3 or enrolled under part B, or both, with respect to whom
4 claims are submitted for claims processing, a toll-free tele-
5 phone number at which such individuals, providers of serv-
6 ices and suppliers may obtain information regarding billing,
7 coding, claims, coverage, and other appropriate information
8 under this title.

9 “(4) MONITORING OF CONTRACTOR RESPONSES.—

10 “(A) IN GENERAL.—Each medicare administrative
11 contractor shall, consistent with standards developed by
12 the Secretary under subparagraph (B)—

13 “(i) maintain a system for identifying who
14 provides the information referred to in paragraphs
15 (2) and (3); and

16 “(ii) monitor the accuracy, consistency, and
17 timeliness of the information so provided.

18 “(B) DEVELOPMENT OF STANDARDS.—

19 “(i) IN GENERAL.—The Secretary shall estab-
20 lish and make public standards to monitor the ac-
21 curacy, consistency, and timeliness of the informa-
22 tion provided in response to written and telephone
23 inquiries under this subsection. Such standards
24 shall be consistent with the performance require-
25 ments established under subsection (b)(3).

26 “(ii) EVALUATION.—In conducting evaluations
27 of individual medicare administrative contractors,
28 the Secretary shall take into account the results of
29 the monitoring conducted under subparagraph (A)
30 taking into account as performance requirements
31 the standards established under clause (i). The
32 Secretary shall, in consultation with organizations
33 representing providers of services, suppliers, and
34 individuals entitled to benefits under part A or en-
35 rolled under part B, or both, establish standards
36 relating to the accuracy, consistency, and timeliness
37 of the information so provided.

1 “(C) DIRECT MONITORING.—Nothing in this para-
2 graph shall be construed as preventing the Secretary
3 from directly monitoring the accuracy, consistency, and
4 timeliness of the information so provided.”.

5 (2) EFFECTIVE DATE.—The amendment made by
6 paragraph (1) shall take effect October 1, 2004.

7 (3) APPLICATION TO FISCAL INTERMEDIARIES AND
8 CARRIERS.—The provisions of section 1874A(g) of the So-
9 cial Security Act, as added by paragraph (1), shall apply
10 to each fiscal intermediary under section 1816 of the Social
11 Security Act (42 U.S.C. 1395h) and each carrier under
12 section 1842 of such Act (42 U.S.C. 1395u) in the same
13 manner as they apply to medicare administrative contrac-
14 tors under such provisions.

15 (d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

16 (1) IN GENERAL.—Section 1889, as added by sub-
17 section (a), is amended by adding at the end the following
18 new subsections:

19 “(b) ENHANCED EDUCATION AND TRAINING.—

20 “(1) ADDITIONAL RESOURCES.—There are authorized
21 to be appropriated to the Secretary (in appropriate part
22 from the Federal Hospital Insurance Trust Fund and the
23 Federal Supplementary Medical Insurance Trust Fund)
24 \$25,000,000 for each of fiscal years 2005 and 2006 and
25 such sums as may be necessary for succeeding fiscal years.

26 “(2) USE.—The funds made available under para-
27 graph (1) shall be used to increase the conduct by medicare
28 contractors of education and training of providers of serv-
29 ices and suppliers regarding billing, coding, and other ap-
30 propriate items and may also be used to improve the accu-
31 racy, consistency, and timeliness of contractor responses.

32 “(c) TAILORING EDUCATION AND TRAINING ACTIVITIES
33 FOR SMALL PROVIDERS OR SUPPLIERS.—

34 “(1) IN GENERAL.—Insofar as a medicare contractor
35 conducts education and training activities, it shall tailor
36 such activities to meet the special needs of small providers
37 of services or suppliers (as defined in paragraph (2)).

1 “(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—

2 In this subsection, the term ‘small provider of services or
3 supplier’ means—

4 “(A) a provider of services with fewer than 25 full-
5 time-equivalent employees; or

6 “(B) a supplier with fewer than 10 full-time-equiv-
7 alent employees.”.

8 (2) EFFECTIVE DATE.—The amendment made by
9 paragraph (1) shall take effect on October 1, 2004.

10 (e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

11 (1) IN GENERAL.—Section 1889, as added by sub-
12 section (a) and as amended by subsection (d), is further
13 amended by adding at the end the following new sub-
14 section:

15 “(d) INTERNET SITES; FAQs.—The Secretary, and each
16 medicare contractor insofar as it provides services (including
17 claims processing) for providers of services or suppliers, shall
18 maintain an Internet site which—

19 “(1) provides answers in an easily accessible format to
20 frequently asked questions, and

21 “(2) includes other published materials of the con-
22 tractor,

23 that relate to providers of services and suppliers under the pro-
24 grams under this title (and title XI insofar as it relates to such
25 programs).”.

26 (2) EFFECTIVE DATE.—The amendment made by
27 paragraph (1) shall take effect on October 1, 2004.

28 (f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

29 (1) IN GENERAL.—Section 1889, as added by sub-
30 section (a) and as amended by subsections (d) and (e), is
31 further amended by adding at the end the following new
32 subsections:

33 “(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION
34 PROGRAM ACTIVITIES.—A medicare contractor may not use a
35 record of attendance at (or failure to attend) educational activi-
36 ties or other information gathered during an educational pro-
37 gram conducted under this section or otherwise by the Sec-

1 retary to select or track providers of services or suppliers for
2 the purpose of conducting any type of audit or prepayment re-
3 view.

4 “(f) CONSTRUCTION.—Nothing in this section or section
5 1893(g) shall be construed as providing for disclosure by a
6 medicare contractor of information that would compromise
7 pending law enforcement activities or reveal findings of law en-
8 forcement-related audits.

9 “(g) DEFINITIONS.—For purposes of this section, the
10 term ‘medicare contractor’ includes the following:

11 “(1) A medicare administrative contractor with a con-
12 tract under section 1874A, including a fiscal intermediary
13 with a contract under section 1816 and a carrier with a
14 contract under section 1842.

15 “(2) An eligible entity with a contract under section
16 1893.

17 Such term does not include, with respect to activities of a spe-
18 cific provider of services or supplier an entity that has no au-
19 thority under this title or title IX with respect to such activities
20 and such provider of services or supplier.”.

21 “(2) EFFECTIVE DATE.—The amendment made by
22 paragraph (1) shall take effect on the date of the enact-
23 ment of this Act.

24 **SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE**
25 **DEMONSTRATION PROGRAM.**

26 (a) ESTABLISHMENT.—

27 “(1) IN GENERAL.—The Secretary shall establish a
28 demonstration program (in this section referred to as the
29 “demonstration program”) under which technical assist-
30 ance described in paragraph (2) is made available, upon re-
31 quest and on a voluntary basis, to small providers of serv-
32 ices or suppliers in order to improve compliance with the
33 applicable requirements of the programs under medicare
34 program under title XVIII of the Social Security Act (in-
35 cluding provisions of title XI of such Act insofar as they
36 relate to such title and are not administered by the Office

1 of the Inspector General of the Department of Health and
2 Human Services).

3 (2) FORMS OF TECHNICAL ASSISTANCE.—The tech-
4 nical assistance described in this paragraph is—

5 (A) evaluation and recommendations regarding
6 billing and related systems; and

7 (B) information and assistance regarding policies
8 and procedures under the medicare program, including
9 coding and reimbursement.

10 (3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—
11 In this section, the term “small providers of services or
12 suppliers” means—

13 (A) a provider of services with fewer than 25 full-
14 time-equivalent employees; or

15 (B) a supplier with fewer than 10 full-time-equiva-
16 lent employees.

17 (b) QUALIFICATION OF CONTRACTORS.—In conducting the
18 demonstration program, the Secretary shall enter into contracts
19 with qualified organizations (such as peer review organizations
20 or entities described in section 1889(g)(2) of the Social Secu-
21 rity Act, as inserted by section 5(f)(1)) with appropriate exper-
22 tise with billing systems of the full range of providers of serv-
23 ices and suppliers to provide the technical assistance. In award-
24 ing such contracts, the Secretary shall consider any prior inves-
25 tigations of the entity’s work by the Inspector General of De-
26 partment of Health and Human Services or the Comptroller
27 General of the United States.

28 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The tech-
29 nical assistance provided under the demonstration program
30 shall include a direct and in-person examination of billing sys-
31 tems and internal controls of small providers of services or sup-
32 pliers to determine program compliance and to suggest more
33 efficient or effective means of achieving such compliance.

34 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS
35 IDENTIFIED AS CORRECTED.—The Secretary shall provide
36 that, absent evidence of fraud and notwithstanding any other
37 provision of law, any errors found in a compliance review for

1 a small provider of services or supplier that participates in the
2 demonstration program shall not be subject to recovery action
3 if the technical assistance personnel under the program deter-
4 mine that—

5 (1) the problem that is the subject of the compliance
6 review has been corrected to their satisfaction within 30
7 days of the date of the visit by such personnel to the small
8 provider of services or supplier; and

9 (2) such problem remains corrected for such period as
10 is appropriate.

11 The previous sentence applies only to claims filed as part of the
12 demonstration program and lasts only for the duration of such
13 program and only as long as the small provider of services or
14 supplier is a participant in such program.

15 (e) GAO EVALUATION.—Not later than 2 years after the
16 date of the date the demonstration program is first imple-
17 mented, the Comptroller General, in consultation with the In-
18 spector General of the Department of Health and Human Serv-
19 ices, shall conduct an evaluation of the demonstration program.
20 The evaluation shall include a determination of whether claims
21 error rates are reduced for small providers of services or sup-
22 pliers who participated in the program and the extent of im-
23 proper payments made as a result of the demonstration pro-
24 gram. The Comptroller General shall submit a report to the
25 Secretary and the Congress on such evaluation and shall in-
26 clude in such report recommendations regarding the continu-
27 ation or extension of the demonstration program.

28 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The pro-
29 vision of technical assistance to a small provider of services or
30 supplier under the demonstration program is conditioned upon
31 the small provider of services or supplier paying an amount es-
32 timated (and disclosed in advance of a provider's or supplier's
33 participation in the program) to be equal to 25 percent of the
34 cost of the technical assistance.

35 (g) AUTHORIZATION OF APPROPRIATIONS.—There are au-
36 thorized to be appropriated to the Secretary (in appropriate
37 part from the Federal Hospital Insurance Trust Fund and the

1 Federal Supplementary Medical Insurance Trust Fund) to
2 carry out the demonstration program—

3 (1) for fiscal year 2005, \$1,000,000, and

4 (2) for fiscal year 2006, \$6,000,000.

5 **SEC. 923. MEDICARE PROVIDER OMBUDSMAN; MEDI-**
6 **CARE BENEFICIARY OMBUDSMAN.**

7 (a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868
8 (42 U.S.C. 1395ee) is amended—

9 (1) by adding at the end of the heading the following:

10 “; MEDICARE PROVIDER OMBUDSMAN”;

11 (2) by inserting “PRACTICING PHYSICIANS ADVISORY
12 COUNCIL.—(1)” after “(a)”;

13 (3) in paragraph (1), as so redesignated under para-
14 graph (2), by striking “in this section” and inserting “in
15 this subsection”;

16 (4) by redesignating subsections (b) and (c) as para-
17 graphs (2) and (3), respectively; and

18 (5) by adding at the end the following new subsection:

19 “(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary
20 shall appoint within the Department of Health and Human
21 Services a Medicare Provider Ombudsman. The Ombudsman
22 shall—

23 “(1) provide assistance, on a confidential basis, to pro-
24 viders of services and suppliers with respect to complaints,
25 grievances, and requests for information concerning the
26 programs under this title (including provisions of title XI
27 insofar as they relate to this title and are not administered
28 by the Office of the Inspector General of the Department
29 of Health and Human Services) and in the resolution of
30 unclear or conflicting guidance given by the Secretary and
31 medicare contractors to such providers of services and sup-
32 pliers regarding such programs and provisions and require-
33 ments under this title and such provisions; and

34 “(2) submit recommendations to the Secretary for im-
35 provement in the administration of this title and such pro-
36 visions, including—

1 “(A) recommendations to respond to recurring
2 patterns of confusion in this title and such provisions
3 (including recommendations regarding suspending im-
4 position of sanctions where there is widespread confu-
5 sion in program administration), and

6 “(B) recommendations to provide for an appro-
7 priate and consistent response (including not providing
8 for audits) in cases of self-identified overpayments by
9 providers of services and suppliers.

10 The Ombudsman shall not serve as an advocate for any in-
11 creases in payments or new coverage of services, but may iden-
12 tify issues and problems in payment or coverage policies.”.

13 (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII,
14 as previously amended, is amended by inserting after section
15 1809 the following new section:

16 “MEDICARE BENEFICIARY OMBUDSMAN

17 “SEC. 1810. (a) IN GENERAL.—The Secretary shall ap-
18 point within the Department of Health and Human Services a
19 Medicare Beneficiary Ombudsman who shall have expertise and
20 experience in the fields of health care and education of (and
21 assistance to) individuals entitled to benefits under this title.

22 “(b) DUTIES.—The Medicare Beneficiary Ombudsman
23 shall—

24 “(1) receive complaints, grievances, and requests for
25 information submitted by individuals entitled to benefits
26 under part A or enrolled under part B, or both, with re-
27 spect to any aspect of the medicare program;

28 “(2) provide assistance with respect to complaints,
29 grievances, and requests referred to in paragraph (1),
30 including—

31 “(A) assistance in collecting relevant information
32 for such individuals, to seek an appeal of a decision or
33 determination made by a fiscal intermediary, carrier,
34 Medicare+Choice organization, or the Secretary; and

35 “(B) assistance to such individuals with any prob-
36 lems arising from disenrollment from a
37 Medicare+Choice plan under part C; and

1 “(3) submit annual reports to Congress and the Sec-
2 retary that describe the activities of the Office and that in-
3 clude such recommendations for improvement in the admin-
4 istration of this title as the Ombudsman determines appro-
5 priate.

6 The Ombudsman shall not serve as an advocate for any in-
7 creases in payments or new coverage of services, but may iden-
8 tify issues and problems in payment or coverage policies.

9 “(c) WORKING WITH HEALTH INSURANCE COUNSELING
10 PROGRAMS.—To the extent possible, the Ombudsman shall
11 work with health insurance counseling programs (receiving
12 funding under section 4360 of Omnibus Budget Reconciliation
13 Act of 1990) to facilitate the provision of information to indi-
14 viduals entitled to benefits under part A or enrolled under part
15 B, or both regarding Medicare+Choice plans and changes to
16 those plans. Nothing in this subsection shall preclude further
17 collaboration between the Ombudsman and such programs.”.

18 (c) DEADLINE FOR APPOINTMENT.—The Secretary shall
19 appoint the Medicare Provider Ombudsman and the Medicare
20 Beneficiary Ombudsman, under the amendments made by sub-
21 sections (a) and (b), respectively, by not later than 1 year after
22 the date of the enactment of this Act.

23 (d) FUNDING.—There are authorized to be appropriated to
24 the Secretary (in appropriate part from the Federal Hospital
25 Insurance Trust Fund and the Federal Supplementary Medical
26 Insurance Trust Fund) to carry out the provisions of sub-
27 section (b) of section 1868 of the Social Security Act (relating
28 to the Medicare Provider Ombudsman), as added by subsection
29 (a)(5) and section 1807 of such Act (relating to the Medicare
30 Beneficiary Ombudsman), as added by subsection (b), such
31 sums as are necessary for fiscal year 2004 and each succeeding
32 fiscal year.

33 (e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-
34 MEDICARE).—

35 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE
36 HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—
37 Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by

1 adding at the end the following: “The Secretary shall pro-
2 vide, through the toll-free number 1–800–MEDICARE, for
3 a means by which individuals seeking information about, or
4 assistance with, such programs who phone such toll-free
5 number are transferred (without charge) to appropriate en-
6 tities for the provision of such information or assistance.
7 Such toll-free number shall be the toll-free number listed
8 for general information and assistance in the annual notice
9 under subsection (a) instead of the listing of numbers of
10 individual contractors.”.

11 (2) MONITORING ACCURACY.—

12 (A) STUDY.—The Comptroller General of the
13 United States shall conduct a study to monitor the ac-
14 curacy and consistency of information provided to indi-
15 viduals entitled to benefits under part A or enrolled
16 under part B, or both, through the toll-free number 1–
17 800–MEDICARE, including an assessment of whether
18 the information provided is sufficient to answer ques-
19 tions of such individuals. In conducting the study, the
20 Comptroller General shall examine the education and
21 training of the individuals providing information
22 through such number.

23 (B) REPORT.—Not later than 1 year after the
24 date of the enactment of this Act, the Comptroller Gen-
25 eral shall submit to Congress a report on the study
26 conducted under subparagraph (A).

27 **SEC. 924. BENEFICIARY OUTREACH DEMONSTRATION**
28 **PROGRAM.**

29 (a) IN GENERAL.—The Secretary shall establish a dem-
30 onstration program (in this section referred to as the “dem-
31 onstration program”) under which medicare specialists em-
32 ployed by the Department of Health and Human Services pro-
33 vide advice and assistance to individuals entitled to benefits
34 under part A of title XVIII of the Social Security Act, or en-
35 rolled under part B of such title, or both, regarding the medi-
36 care program at the location of existing local offices of the So-
37 cial Security Administration.

1 (b) LOCATIONS.—

2 (1) IN GENERAL.—The demonstration program shall
3 be conducted in at least 6 offices or areas. Subject to para-
4 graph (2), in selecting such offices and areas, the Secretary
5 shall provide preference for offices with a high volume of
6 visits by individuals referred to in subsection (a).

7 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—The
8 Secretary shall provide for the selection of at least 2 rural
9 areas to participate in the demonstration program. In con-
10 ducting the demonstration program in such rural areas, the
11 Secretary shall provide for medicare specialists to travel
12 among local offices in a rural area on a scheduled basis.

13 (c) DURATION.—The demonstration program shall be con-
14 ducted over a 3-year period.

15 (d) EVALUATION AND REPORT.—

16 (1) EVALUATION.—The Secretary shall provide for an
17 evaluation of the demonstration program. Such evaluation
18 shall include an analysis of—

19 (A) utilization of, and satisfaction of those individ-
20 uals referred to in subsection (a) with, the assistance
21 provided under the program; and

22 (B) the cost-effectiveness of providing beneficiary
23 assistance through out-stationing medicare specialists
24 at local offices of the Social Security Administration.

25 (2) REPORT.—The Secretary shall submit to Congress
26 a report on such evaluation and shall include in such report
27 recommendations regarding the feasibility of permanently
28 out-stationing medicare specialists at local offices of the So-
29 cial Security Administration.

30 **SEC. 925. INCLUSION OF ADDITIONAL INFORMATION IN**
31 **NOTICES TO BENEFICIARIES ABOUT**
32 **SKILLED NURSING FACILITY BENEFITS.**

33 (a) IN GENERAL.—The Secretary shall provide that in
34 medicare beneficiary notices provided (under section 1806(a) of
35 the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to
36 the provision of post-hospital extended care services under part
37 A of title XVIII of the Social Security Act, there shall be in-

1 cluded information on the number of days of coverage of such
2 services remaining under such part for the medicare beneficiary
3 and spell of illness involved.

4 (b) EFFECTIVE DATE.—Subsection (a) shall apply to no-
5 tices provided during calendar quarters beginning more than 6
6 months after the date of the enactment of this Act.

7 **SEC. 926. INFORMATION ON MEDICARE-CERTIFIED**
8 **SKILLED NURSING FACILITIES IN HOSPITAL**
9 **DISCHARGE PLANS.**

10 (a) AVAILABILITY OF DATA.—The Secretary shall publicly
11 provide information that enables hospital discharge planners,
12 medicare beneficiaries, and the public to identify skilled nursing
13 facilities that are participating in the medicare program.

14 (b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL
15 DISCHARGE PLANS.—

16 (1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C.
17 1395x(ee)(2)(D)) is amended—

18 (A) by striking “hospice services” and inserting
19 “hospice care and post-hospital extended care services”;
20 and

21 (B) by inserting before the period at the end the
22 following: “and, in the case of individuals who are like-
23 ly to need post-hospital extended care services, the
24 availability of such services through facilities that par-
25 ticipate in the program under this title and that serve
26 the area in which the patient resides”.

27 (2) EFFECTIVE DATE.—The amendments made by
28 paragraph (1) shall apply to discharge plans made on or
29 after such date as the Secretary shall specify, but not later
30 than 6 months after the date the Secretary provides for
31 availability of information under subsection (a).

32 **Subtitle D—Appeals and Recovery**

33 **SEC. 931. TRANSFER OF RESPONSIBILITY FOR MEDI-**
34 **CARE APPEALS.**

35 (a) TRANSITION PLAN.—

36 (1) IN GENERAL.—Not later than October 1, 2004,
37 the Commissioner of Social Security and the Secretary

1 shall develop and transmit to Congress and the Comptroller
2 General of the United States a plan under which the func-
3 tions of administrative law judges responsible for hearing
4 cases under title XVIII of the Social Security Act (and re-
5 lated provisions in title XI of such Act) are transferred
6 from the responsibility of the Commissioner and the Social
7 Security Administration to the Secretary and the Depart-
8 ment of Health and Human Services.

9 (2) GAO EVALUATION.—The Comptroller General of
10 the United States shall evaluate the plan and, not later
11 than the date that is 6 months after the date on which the
12 plan is received by the Comptroller General, shall submit
13 to Congress a report on such evaluation.

14 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

15 (1) IN GENERAL.—Not earlier than July 1, 2005, and
16 not later than October 1, 2005, the Commissioner of Social
17 Security and the Secretary shall implement the transition
18 plan under subsection (a) and transfer the administrative
19 law judge functions described in such subsection from the
20 Social Security Administration to the Secretary.

21 (2) ASSURING INDEPENDENCE OF JUDGES.—The Sec-
22 retary shall assure the independence of administrative law
23 judges performing the administrative law judge functions
24 transferred under paragraph (1) from the Centers for
25 Medicare & Medicaid Services and its contractors. In order
26 to assure such independence, the Secretary shall place such
27 judges in an administrative office that is organizationally
28 and functionally separate from such Centers. Such judges
29 shall report to, and be under the general supervision of, the
30 Secretary, but shall not report to, or be subject to super-
31 vision by, another other officer of the Department.

32 (3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall
33 provide for an appropriate geographic distribution of ad-
34 ministrative law judges performing the administrative law
35 judge functions transferred under paragraph (1) through-
36 out the United States to ensure timely access to such
37 judges.

1 (4) HIRING AUTHORITY.—Subject to the amounts pro-
2 vided in advance in appropriations Act, the Secretary shall
3 have authority to hire administrative law judges to hear
4 such cases, giving priority to those judges with prior experi-
5 ence in handling medicare appeals and in a manner con-
6 sistent with paragraph (3), and to hire support staff for
7 such judges.

8 (5) FINANCING.—Amounts payable under law to the
9 Commissioner for administrative law judges performing the
10 administrative law judge functions transferred under para-
11 graph (1) from the Federal Hospital Insurance Trust Fund
12 and the Federal Supplementary Medical Insurance Trust
13 Fund shall become payable to the Secretary for the func-
14 tions so transferred.

15 (6) SHARED RESOURCES.—The Secretary shall enter
16 into such arrangements with the Commissioner as may be
17 appropriate with respect to transferred functions of admin-
18 istrative law judges to share office space, support staff, and
19 other resources, with appropriate reimbursement from the
20 Trust Funds described in paragraph (5).

21 (c) INCREASED FINANCIAL SUPPORT.—In addition to any
22 amounts otherwise appropriated, to ensure timely action on ap-
23 peals before administrative law judges and the Departmental
24 Appeals Board consistent with section 1869 of the Social Secu-
25 rity Act (as amended by section 521 of BIPA, 114 Stat.
26 2763A–534), there are authorized to be appropriated (in appro-
27 priate part from the Federal Hospital Insurance Trust Fund
28 and the Federal Supplementary Medical Insurance Trust
29 Fund) to the Secretary such sums as are necessary for fiscal
30 year 2005 and each subsequent fiscal year to—

31 (1) increase the number of administrative law judges
32 (and their staffs) under subsection (b)(4);

33 (2) improve education and training opportunities for
34 administrative law judges (and their staffs); and

35 (3) increase the staff of the Departmental Appeals
36 Board.

1 (d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i)
2 (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of
3 BIPA (114 Stat. 2763A–543), is amended by striking “of the
4 Social Security Administration”.

5 **SEC. 932. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

6 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section
7 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is
8 amended—

9 (1) in paragraph (1)(A), by inserting “, subject to
10 paragraph (2),” before “to judicial review of the Sec-
11 retary’s final decision”;

12 (2) in paragraph (1)(F)—

13 (A) by striking clause (ii);

14 (B) by striking “PROCEEDING” and all that follows
15 through “DETERMINATION” and inserting “DETER-
16 MINATIONS AND RECONSIDERATIONS”; and

17 (C) by redesignating subclauses (I) and (II) as
18 clauses (i) and (ii) and by moving the indentation of
19 such subclauses (and the matter that follows) 2 ems to
20 the left; and

21 (3) by adding at the end the following new paragraph:

22 “(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

23 “(A) IN GENERAL.—The Secretary shall establish
24 a process under which a provider of services or supplier
25 that furnishes an item or service or an individual enti-
26 tled to benefits under part A or enrolled under part B,
27 or both, who has filed an appeal under paragraph (1)
28 may obtain access to judicial review when a review
29 panel (described in subparagraph (D)), on its own mo-
30 tion or at the request of the appellant, determines that
31 no entity in the administrative appeals process has the
32 authority to decide the question of law or regulation
33 relevant to the matters in controversy and that there
34 is no material issue of fact in dispute. The appellant
35 may make such request only once with respect to a
36 question of law or regulation in a case of an appeal.

1 “(B) PROMPT DETERMINATIONS.—If, after or co-
2 incident with appropriately filing a request for an ad-
3 ministrative hearing, the appellant requests a deter-
4 mination by the appropriate review panel that no re-
5 view panel has the authority to decide the question of
6 law or regulations relevant to the matters in con-
7 troversy and that there is no material issue of fact in
8 dispute and if such request is accompanied by the doc-
9 uments and materials as the appropriate review panel
10 shall require for purposes of making such determina-
11 tion, such review panel shall make a determination on
12 the request in writing within 60 days after the date
13 such review panel receives the request and such accom-
14 panying documents and materials. Such a determina-
15 tion by such review panel shall be considered a final de-
16 cision and not subject to review by the Secretary.

17 “(C) ACCESS TO JUDICIAL REVIEW.—

18 “(i) IN GENERAL.—If the appropriate review
19 panel—

20 “(I) determines that there are no material
21 issues of fact in dispute and that the only issue
22 is one of law or regulation that no review panel
23 has the authority to decide; or

24 “(II) fails to make such determination
25 within the period provided under subparagraph
26 (B);

27 then the appellant may bring a civil action as de-
28 scribed in this subparagraph.

29 “(ii) DEADLINE FOR FILING.—Such action
30 shall be filed, in the case described in—

31 “(I) clause (i)(I), within 60 days of date
32 of the determination described in such subpara-
33 graph; or

34 “(II) clause (i)(II), within 60 days of the
35 end of the period provided under subparagraph
36 (B) for the determination.

1 “(iii) VENUE.—Such action shall be brought
2 in the district court of the United States for the ju-
3 dicial district in which the appellant is located (or,
4 in the case of an action brought jointly by more
5 than one applicant, the judicial district in which
6 the greatest number of applicants are located) or in
7 the district court for the District of Columbia.

8 “(iv) INTEREST ON AMOUNTS IN CON-
9 TROVERSY.—Where a provider of services or sup-
10 plier seeks judicial review pursuant to this para-
11 graph, the amount in controversy shall be subject
12 to annual interest beginning on the first day of the
13 first month beginning after the 60-day period as
14 determined pursuant to clause (ii) and equal to the
15 rate of interest on obligations issued for purchase
16 by the Federal Hospital Insurance Trust Fund and
17 by the Federal Supplementary Medical Insurance
18 Trust Fund for the month in which the civil action
19 authorized under this paragraph is commenced, to
20 be awarded by the reviewing court in favor of the
21 prevailing party. No interest awarded pursuant to
22 the preceding sentence shall be deemed income or
23 cost for the purposes of determining reimbursement
24 due providers of services or suppliers under this
25 Act.

26 “(D) REVIEW PANELS.—For purposes of this sub-
27 section, a ‘review panel’ is a panel consisting of 3 mem-
28 bers (who shall be administrative law judges, members
29 of the Departmental Appeals Board, or qualified indi-
30 viduals associated with a qualified independent con-
31 tractor (as defined in subsection (c)(2)) or with another
32 independent entity) designated by the Secretary for
33 purposes of making determinations under this para-
34 graph.”.

35 (b) APPLICATION TO PROVIDER AGREEMENT DETERMINA-
36 TIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is
37 amended—

1 (1) by inserting “(A)” after “(h)(1)”; and

2 (2) by adding at the end the following new subpara-
3 graph:

4 “(B) An institution or agency described in subparagraph
5 (A) that has filed for a hearing under subparagraph (A) shall
6 have expedited access to judicial review under this subpara-
7 graph in the same manner as providers of services, suppliers,
8 and individuals entitled to benefits under part A or enrolled
9 under part B, or both, may obtain expedited access to judicial
10 review under the process established under section 1869(b)(2).
11 Nothing in this subparagraph shall be construed to affect the
12 application of any remedy imposed under section 1819 during
13 the pendency of an appeal under this subparagraph.”.

14 (c) EFFECTIVE DATE.—The amendments made by this
15 section shall apply to appeals filed on or after October 1, 2004.

16 (d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREE-
17 MENT DETERMINATIONS.—

18 (1) TERMINATION AND CERTAIN OTHER IMMEDIATE
19 REMEDIES.—The Secretary shall develop and implement a
20 process to expedite proceedings under sections 1866(h) of
21 the Social Security Act (42 U.S.C. 1395cc(h)) in which the
22 remedy of termination of participation, or a remedy de-
23 scribed in clause (i) or (iii) of section 1819(h)(2)(B) of
24 such Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied on
25 an immediate basis, has been imposed. Under such process
26 priority shall be provided in cases of termination.

27 (2) INCREASED FINANCIAL SUPPORT.—In addition to
28 any amounts otherwise appropriated, to reduce by 50 per-
29 cent the average time for administrative determinations on
30 appeals under section 1866(h) of the Social Security Act
31 (42 U.S.C. 1395cc(h)), there are authorized to be appro-
32 priated (in appropriate part from the Federal Hospital In-
33 surance Trust Fund and the Federal Supplementary Med-
34 ical Insurance Trust Fund) to the Secretary such addi-
35 tional sums for fiscal year 2005 and each subsequent fiscal
36 year as may be necessary. The purposes for which such
37 amounts are available include increasing the number of ad-

1 ministrative law judges (and their staffs) and the appellate
2 level staff at the Departmental Appeals Board of the De-
3 partment of Health and Human Services and educating
4 such judges and staffs on long-term care issues.

5 **SEC. 933. REVISIONS TO MEDICARE APPEALS PROCESS.**

6 (a) REQUIRING FULL AND EARLY PRESENTATION OF EVI-
7 DENCE.—

8 (1) IN GENERAL.—Section 1869(b) (42 U.S.C.
9 1395ff(b)), as amended by BIPA and as amended by sec-
10 tion 932(a), is further amended by adding at the end the
11 following new paragraph:

12 “(3) REQUIRING FULL AND EARLY PRESENTATION OF
13 EVIDENCE BY PROVIDERS.—A provider of services or sup-
14 plier may not introduce evidence in any appeal under this
15 section that was not presented at the reconsideration con-
16 ducted by the qualified independent contractor under sub-
17 section (c), unless there is good cause which precluded the
18 introduction of such evidence at or before that reconsider-
19 ation.”.

20 (2) EFFECTIVE DATE.—The amendment made by
21 paragraph (1) shall take effect on October 1, 2004.

22 (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section
23 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended
24 by BIPA, is amended by inserting “(including the medical
25 records of the individual involved)” after “clinical experience”.

26 (c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

27 (1) INITIAL DETERMINATIONS AND REDETERMINA-
28 TIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amend-
29 ed by BIPA, is amended by adding at the end the following
30 new paragraphs:

31 “(4) REQUIREMENTS OF NOTICE OF DETERMINA-
32 TIONS.—With respect to an initial determination insofar as
33 it results in a denial of a claim for benefits—

34 “(A) the written notice on the determination shall
35 include—

1 “(i) the reasons for the determination, includ-
2 ing whether a local medical review policy or a local
3 coverage determination was used;

4 “(ii) the procedures for obtaining additional
5 information concerning the determination, includ-
6 ing the information described in subparagraph (B);
7 and

8 “(iii) notification of the right to seek a rede-
9 termination or otherwise appeal the determination
10 and instructions on how to initiate such a redeter-
11 mination under this section; and

12 “(B) the person provided such notice may obtain,
13 upon request, the specific provision of the policy, man-
14 ual, or regulation used in making the determination.

15 “(5) REQUIREMENTS OF NOTICE OF REDETERMINA-
16 TIONS.—With respect to a redetermination insofar as it re-
17 sults in a denial of a claim for benefits—

18 “(A) the written notice on the redetermination
19 shall include—

20 “(i) the specific reasons for the redetermina-
21 tion;

22 “(ii) as appropriate, a summary of the clinical
23 or scientific evidence used in making the redeter-
24 mination;

25 “(iii) a description of the procedures for ob-
26 taining additional information concerning the rede-
27 termination; and

28 “(iv) notification of the right to appeal the re-
29 determination and instructions on how to initiate
30 such an appeal under this section;

31 “(B) such written notice shall be provided in
32 printed form and written in a manner calculated to be
33 understood by the individual entitled to benefits under
34 part A or enrolled under part B, or both; and

35 “(C) the person provided such notice may obtain,
36 upon request, information on the specific provision of

1 the policy, manual, or regulation used in making the
2 redetermination.”.

3 (2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42
4 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is
5 amended—

6 (A) by inserting “be written in a manner cal-
7 culated to be understood by the individual entitled to
8 benefits under part A or enrolled under part B, or
9 both, and shall include (to the extent appropriate)”
10 after “in writing, ”; and

11 (B) by inserting “and a notification of the right to
12 appeal such determination and instructions on how to
13 initiate such appeal under this section” after “such de-
14 cision,”.

15 (3) APPEALS.—Section 1869(d) (42 U.S.C.
16 1395ff(d)), as amended by BIPA, is amended—

17 (A) in the heading, by inserting “; NOTICE” after
18 “SECRETARY”; and

19 (B) by adding at the end the following new para-
20 graph:

21 “(4) NOTICE.—Notice of the decision of an adminis-
22 trative law judge shall be in writing in a manner calculated
23 to be understood by the individual entitled to benefits
24 under part A or enrolled under part B, or both, and shall
25 include—

26 “(A) the specific reasons for the determination (in-
27 cluding, to the extent appropriate, a summary of the
28 clinical or scientific evidence used in making the deter-
29 mination);

30 “(B) the procedures for obtaining additional infor-
31 mation concerning the decision; and

32 “(C) notification of the right to appeal the deci-
33 sion and instructions on how to initiate such an appeal
34 under this section.”.

35 (4) SUBMISSION OF RECORD FOR APPEAL.—Section
36 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking
37 “prepare” and inserting “submit” and by striking “with re-

1 spect to” and all that follows through “and relevant poli-
2 cies”.

3 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

4 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDE-
5 PENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C.
6 1395ff(c)(3)), as amended by BIPA, is amended—

7 (A) in subparagraph (A), by striking “sufficient
8 training and expertise in medical science and legal mat-
9 ters” and inserting “sufficient medical, legal, and other
10 expertise (including knowledge of the program under
11 this title) and sufficient staffing”; and

12 (B) by adding at the end the following new sub-
13 paragraph:

14 “(K) INDEPENDENCE REQUIREMENTS.—

15 “(i) IN GENERAL.—Subject to clause (ii), a
16 qualified independent contractor shall not conduct
17 any activities in a case unless the entity—

18 “(I) is not a related party (as defined in
19 subsection (g)(5));

20 “(II) does not have a material familial, fi-
21 nancial, or professional relationship with such a
22 party in relation to such case; and

23 “(III) does not otherwise have a conflict of
24 interest with such a party.

25 “(ii) EXCEPTION FOR REASONABLE COM-
26 PENSATION.—Nothing in clause (i) shall be con-
27 strued to prohibit receipt by a qualified inde-
28 pendent contractor of compensation from the Sec-
29 retary for the conduct of activities under this sec-
30 tion if the compensation is provided consistent with
31 clause (iii).

32 “(iii) LIMITATIONS ON ENTITY COMPENSA-
33 TION.—Compensation provided by the Secretary to
34 a qualified independent contractor in connection
35 with reviews under this section shall not be contin-
36 gent on any decision rendered by the contractor or
37 by any reviewing professional.”.

1 (2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—
2 Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is
3 amended—

4 (A) by amending subsection (c)(3)(D) to read as
5 follows:

6 “(D) QUALIFICATIONS FOR REVIEWERS.—The re-
7 quirements of subsection (g) shall be met (relating to
8 qualifications of reviewing professionals).”; and

9 (B) by adding at the end the following new sub-
10 section:

11 “(g) QUALIFICATIONS OF REVIEWERS.—

12 “(1) IN GENERAL.—In reviewing determinations under
13 this section, a qualified independent contractor shall assure
14 that—

15 “(A) each individual conducting a review shall
16 meet the qualifications of paragraph (2);

17 “(B) compensation provided by the contractor to
18 each such reviewer is consistent with paragraph (3);
19 and

20 “(C) in the case of a review by a panel described
21 in subsection (c)(3)(B) composed of physicians or other
22 health care professionals (each in this subsection re-
23ferred to as a ‘reviewing professional’), a reviewing pro-
24fessional meets the qualifications described in para-
25graph (4) and, where a claim is regarding the fur-
26nishing of treatment by a physician (allopathic or os-
27teopathic) or the provision of items or services by a
28physician (allopathic or osteopathic), each reviewing
29professional shall be a physician (allopathic or osteo-
30pathic).

31 “(2) INDEPENDENCE.—

32 “(A) IN GENERAL.—Subject to subparagraph (B),
33 each individual conducting a review in a case shall—

34 “(i) not be a related party (as defined in para-
35 graph (5));

1 “(ii) not have a material familial, financial, or
2 professional relationship with such a party in the
3 case under review; and

4 “(iii) not otherwise have a conflict of interest
5 with such a party.

6 “(B) EXCEPTION.—Nothing in subparagraph (A)
7 shall be construed to—

8 “(i) prohibit an individual, solely on the basis
9 of a participation agreement with a fiscal inter-
10 mediary, carrier, or other contractor, from serving
11 as a reviewing professional if—

12 “(I) the individual is not involved in the
13 provision of items or services in the case under
14 review;

15 “(II) the fact of such an agreement is dis-
16 closed to the Secretary and the individual enti-
17 tled to benefits under part A or enrolled under
18 part B, or both, (or authorized representative)
19 and neither party objects; and

20 “(III) the individual is not an employee of
21 the intermediary, carrier, or contractor and
22 does not provide services exclusively or pri-
23 marily to or on behalf of such intermediary,
24 carrier, or contractor;

25 “(ii) prohibit an individual who has staff privi-
26 leges at the institution where the treatment in-
27 volved takes place from serving as a reviewer mere-
28 ly on the basis of having such staff privileges if the
29 existence of such privileges is disclosed to the Sec-
30 retary and such individual (or authorized represent-
31 ative), and neither party objects; or

32 “(iii) prohibit receipt of compensation by a re-
33 viewing professional from a contractor if the com-
34 pensation is provided consistent with paragraph
35 (3).

36 For purposes of this paragraph, the term ‘participation
37 agreement’ means an agreement relating to the provi-

1 sion of health care services by the individual and does
2 not include the provision of services as a reviewer
3 under this subsection.

4 “(3) LIMITATIONS ON REVIEWER COMPENSATION.—
5 Compensation provided by a qualified independent con-
6 tractor to a reviewer in connection with a review under this
7 section shall not be contingent on the decision rendered by
8 the reviewer.

9 “(4) LICENSURE AND EXPERTISE.—Each reviewing
10 professional shall be—

11 “(A) a physician (allopathic or osteopathic) who is
12 appropriately credentialed or licensed in one or more
13 States to deliver health care services and has medical
14 expertise in the field of practice that is appropriate for
15 the items or services at issue; or

16 “(B) a health care professional who is legally au-
17 thorized in one or more States (in accordance with
18 State law or the State regulatory mechanism provided
19 by State law) to furnish the health care items or serv-
20 ices at issue and has medical expertise in the field of
21 practice that is appropriate for such items or services.

22 “(5) RELATED PARTY DEFINED.—For purposes of this
23 section, the term ‘related party’ means, with respect to a
24 case under this title involving a specific individual entitled
25 to benefits under part A or enrolled under part B, or both,
26 any of the following:

27 “(A) The Secretary, the medicare administrative
28 contractor involved, or any fiduciary, officer, director,
29 or employee of the Department of Health and Human
30 Services, or of such contractor.

31 “(B) The individual (or authorized representative).

32 “(C) The health care professional that provides
33 the items or services involved in the case.

34 “(D) The institution at which the items or services
35 (or treatment) involved in the case are provided.

1 “(E) The manufacturer of any drug or other item
2 that is included in the items or services involved in the
3 case.

4 “(F) Any other party determined under any regu-
5 lations to have a substantial interest in the case in-
6 volved.”.

7 (3) REDUCING MINIMUM NUMBER OF QUALIFIED
8 INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42
9 U.S.C. 1395ff(c)(4)) is amended by striking “not fewer
10 than 12 qualified independent contractors under this sub-
11 section” and inserting “with a sufficient number of quali-
12 fied independent contractors (but not fewer than 4 such
13 contractors) to conduct reconsiderations consistent with the
14 timeframes applicable under this subsection”.

15 (4) EFFECTIVE DATE.—The amendments made by
16 paragraphs (1) and (2) shall be effective as if included in
17 the enactment of the respective provisions of subtitle C of
18 title V of BIPA, (114 Stat. 2763A–534).

19 (5) TRANSITION.—In applying section 1869(g) of the
20 Social Security Act (as added by paragraph (2)), any ref-
21 erence to a medicare administrative contractor shall be
22 deemed to include a reference to a fiscal intermediary
23 under section 1816 of the Social Security Act (42 U.S.C.
24 1395h) and a carrier under section 1842 of such Act (42
25 U.S.C. 1395u).

26 **SEC. 934. PREPAYMENT REVIEW.**

27 (a) IN GENERAL.—Section 1874A, as added by section
28 911(a)(1) and as amended by sections 912(b), 921(b)(1), and
29 921(c)(1), is further amended by adding at the end the fol-
30 lowing new subsection:

31 “(h) CONDUCT OF PREPAYMENT REVIEW.—

32 “(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

33 “(A) IN GENERAL.—A medicare administrative
34 contractor may conduct random prepayment review
35 only to develop a contractor-wide or program-wide
36 claims payment error rates or under such additional
37 circumstances as may be provided under regulations,

1 developed in consultation with providers of services and
2 suppliers.

3 “(B) USE OF STANDARD PROTOCOLS WHEN CON-
4 DUCTING PREPAYMENT REVIEWS.—When a medicare
5 administrative contractor conducts a random prepay-
6 ment review, the contractor may conduct such review
7 only in accordance with a standard protocol for random
8 prepayment audits developed by the Secretary.

9 “(C) CONSTRUCTION.—Nothing in this paragraph
10 shall be construed as preventing the denial of payments
11 for claims actually reviewed under a random prepay-
12 ment review.

13 “(D) RANDOM PREPAYMENT REVIEW.—For pur-
14 poses of this subsection, the term ‘random prepayment
15 review’ means a demand for the production of records
16 or documentation absent cause with respect to a claim.

17 “(2) LIMITATIONS ON NON-RANDOM PREPAYMENT RE-
18 VIEW.—

19 “(A) LIMITATIONS ON INITIATION OF NON-RAN-
20 DOM PREPAYMENT REVIEW.—A medicare administra-
21 tive contractor may not initiate non-random prepay-
22 ment review of a provider of services or supplier based
23 on the initial identification by that provider of services
24 or supplier of an improper billing practice unless there
25 is a likelihood of sustained or high level of payment
26 error (as defined in subsection (i)(3)(A)).

27 “(B) TERMINATION OF NON-RANDOM PREPAY-
28 MENT REVIEW.—The Secretary shall issue regulations
29 relating to the termination, including termination
30 dates, of non-random prepayment review. Such regula-
31 tions may vary such a termination date based upon the
32 differences in the circumstances triggering prepayment
33 review.”.

34 (b) EFFECTIVE DATE.—

35 (1) IN GENERAL.—Except as provided in this sub-
36 section, the amendment made by subsection (a) shall take
37 effect 1 year after the date of the enactment of this Act.

1 (2) DEADLINE FOR PROMULGATION OF CERTAIN REG-
2 ULATIONS.—The Secretary shall first issue regulations
3 under section 1874A(h) of the Social Security Act, as
4 added by subsection (a), by not later than 1 year after the
5 date of the enactment of this Act.

6 (3) APPLICATION OF STANDARD PROTOCOLS FOR RAN-
7 DOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of
8 the Social Security Act, as added by subsection (a), shall
9 apply to random prepayment reviews conducted on or after
10 such date (not later than 1 year after the date of the enact-
11 ment of this Act) as the Secretary shall specify.

12 (c) APPLICATION TO FISCAL INTERMEDIARIES AND CAR-
13 RIERS.—The provisions of section 1874A(h) of the Social Secu-
14 rity Act, as added by subsection (a), shall apply to each fiscal
15 intermediary under section 1816 of the Social Security Act (42
16 U.S.C. 1395h) and each carrier under section 1842 of such Act
17 (42 U.S.C. 1395u) in the same manner as they apply to medi-
18 care administrative contractors under such provisions.

19 **SEC. 935. RECOVERY OF OVERPAYMENTS.**

20 (a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is
21 amended by adding at the end the following new subsection:

22 “(f) RECOVERY OF OVERPAYMENTS.—

23 “(1) USE OF REPAYMENT PLANS.—

24 “(A) IN GENERAL.—If the repayment, within 30
25 days by a provider of services or supplier, of an over-
26 payment under this title would constitute a hardship
27 (as defined in subparagraph (B)), subject to subpara-
28 graph (C), upon request of the provider of services or
29 supplier the Secretary shall enter into a plan with the
30 provider of services or supplier for the repayment
31 (through offset or otherwise) of such overpayment over
32 a period of at least 6 months but not longer than 3
33 years (or not longer than 5 years in the case of extreme
34 hardship, as determined by the Secretary). Interest
35 shall accrue on the balance through the period of re-
36 payment. Such plan shall meet terms and conditions
37 determined to be appropriate by the Secretary.

1 “(B) HARDSHIP.—

2 “(i) IN GENERAL.—For purposes of subpara-
3 graph (A), the repayment of an overpayment (or
4 overpayments) within 30 days is deemed to con-
5 stitute a hardship if—

6 “(I) in the case of a provider of services
7 that files cost reports, the aggregate amount of
8 the overpayments exceeds 10 percent of the
9 amount paid under this title to the provider of
10 services for the cost reporting period covered by
11 the most recently submitted cost report; or

12 “(II) in the case of another provider of
13 services or supplier, the aggregate amount of
14 the overpayments exceeds 10 percent of the
15 amount paid under this title to the provider of
16 services or supplier for the previous calendar
17 year.

18 “(ii) RULE OF APPLICATION.—The Secretary
19 shall establish rules for the application of this sub-
20 paragraph in the case of a provider of services or
21 supplier that was not paid under this title during
22 the previous year or was paid under this title only
23 during a portion of that year.

24 “(iii) TREATMENT OF PREVIOUS OVERPAY-
25 MENTS.—If a provider of services or supplier has
26 entered into a repayment plan under subparagraph
27 (A) with respect to a specific overpayment amount,
28 such payment amount under the repayment plan
29 shall not be taken into account under clause (i)
30 with respect to subsequent overpayment amounts.

31 “(C) EXCEPTIONS.—Subparagraph (A) shall not
32 apply if—

33 “(i) the Secretary has reason to suspect that
34 the provider of services or supplier may file for
35 bankruptcy or otherwise cease to do business or
36 discontinue participation in the program under this
37 title; or

1 “(ii) there is an indication of fraud or abuse
2 committed against the program.

3 “(D) IMMEDIATE COLLECTION IF VIOLATION OF
4 REPAYMENT PLAN.—If a provider of services or sup-
5 plier fails to make a payment in accordance with a re-
6 payment plan under this paragraph, the Secretary may
7 immediately seek to offset or otherwise recover the
8 total balance outstanding (including applicable interest)
9 under the repayment plan.

10 “(E) RELATION TO NO FAULT PROVISION.—Noth-
11 ing in this paragraph shall be construed as affecting
12 the application of section 1870(c) (relating to no ad-
13 justment in the cases of certain overpayments).

14 “(2) LIMITATION ON RECOUPMENT.—

15 “(A) IN GENERAL.—In the case of a provider of
16 services or supplier that is determined to have received
17 an overpayment under this title and that seeks a recon-
18 sideration by a qualified independent contractor on
19 such determination under section 1869(b)(1), the Sec-
20 retary may not take any action (or authorize any other
21 person, including any medicare contractor, as defined
22 in subparagraph (C)) to recoup the overpayment until
23 the date the decision on the reconsideration has been
24 rendered. If the provisions of section 1869(b)(1) (pro-
25 viding for such a reconsideration by a qualified inde-
26 pendent contractor) are not in effect, in applying the
27 previous sentence any reference to such a reconsider-
28 ation shall be treated as a reference to a redetermina-
29 tion by the fiscal intermediary or carrier involved.

30 “(B) COLLECTION WITH INTEREST.—Insofar as
31 the determination on such appeal is against the pro-
32 vider of services or supplier, interest on the overpay-
33 ment shall accrue on and after the date of the original
34 notice of overpayment. Insofar as such determination
35 against the provider of services or supplier is later re-
36 versed, the Secretary shall provide for repayment of the
37 amount recouped plus interest at the same rate as

1 would apply under the previous sentence for the period
2 in which the amount was recouped.

3 “(C) MEDICARE CONTRACTOR DEFINED.—For
4 purposes of this subsection, the term ‘medicare con-
5 tractor’ has the meaning given such term in section
6 1889(g).

7 “(3) LIMITATION ON USE OF EXTRAPOLATION.—A
8 medicare contractor may not use extrapolation to determine
9 overpayment amounts to be recovered by recoupment, off-
10 set, or otherwise unless—

11 “(A) there is a sustained or high level of payment
12 error (as defined by the Secretary by regulation); or

13 “(B) documented educational intervention has
14 failed to correct the payment error (as determined by
15 the Secretary).

16 “(4) PROVISION OF SUPPORTING DOCUMENTATION.—
17 In the case of a provider of services or supplier with respect
18 to which amounts were previously overpaid, a medicare con-
19 tractor may request the periodic production of records or
20 supporting documentation for a limited sample of sub-
21 mitted claims to ensure that the previous practice is not
22 continuing.

23 “(5) CONSENT SETTLEMENT REFORMS.—

24 “(A) IN GENERAL.—The Secretary may use a con-
25 sent settlement (as defined in subparagraph (D)) to
26 settle a projected overpayment.

27 “(B) OPPORTUNITY TO SUBMIT ADDITIONAL IN-
28 FORMATION BEFORE CONSENT SETTLEMENT OFFER.—
29 Before offering a provider of services or supplier a con-
30 sent settlement, the Secretary shall—

31 “(i) communicate to the provider of services or
32 supplier—

33 “(I) that, based on a review of the medical
34 records requested by the Secretary, a prelimi-
35 nary evaluation of those records indicates that
36 there would be an overpayment;

1 “(II) the nature of the problems identified
2 in such evaluation; and

3 “(III) the steps that the provider of serv-
4 ices or supplier should take to address the
5 problems; and

6 “(ii) provide for a 45-day period during which
7 the provider of services or supplier may furnish ad-
8 ditional information concerning the medical records
9 for the claims that had been reviewed.

10 “(C) CONSENT SETTLEMENT OFFER.—The Sec-
11 retary shall review any additional information furnished
12 by the provider of services or supplier under subpara-
13 graph (B)(ii). Taking into consideration such informa-
14 tion, the Secretary shall determine if there still appears
15 to be an overpayment. If so, the Secretary—

16 “(i) shall provide notice of such determination
17 to the provider of services or supplier, including an
18 explanation of the reason for such determination;
19 and

20 “(ii) in order to resolve the overpayment, may
21 offer the provider of services or supplier—

22 “(I) the opportunity for a statistically
23 valid random sample; or

24 “(II) a consent settlement.

25 The opportunity provided under clause (ii)(I) does not
26 waive any appeal rights with respect to the alleged
27 overpayment involved.

28 “(D) CONSENT SETTLEMENT DEFINED.—For pur-
29 poses of this paragraph, the term ‘consent settlement’
30 means an agreement between the Secretary and a pro-
31 vider of services or supplier whereby both parties agree
32 to settle a projected overpayment based on less than a
33 statistically valid sample of claims and the provider of
34 services or supplier agrees not to appeal the claims in-
35 volved.

36 “(6) NOTICE OF OVER-UTILIZATION OF CODES.—The
37 Secretary shall establish, in consultation with organizations

1 representing the classes of providers of services and sup-
2 pliers, a process under which the Secretary provides for no-
3 tice to classes of providers of services and suppliers served
4 by the contractor in cases in which the contractor has iden-
5 tified that particular billing codes may be overutilized by
6 that class of providers of services or suppliers under the
7 programs under this title (or provisions of title XI insofar
8 as they relate to such programs).

9 “(7) PAYMENT AUDITS.—

10 “(A) WRITTEN NOTICE FOR POST-PAYMENT AU-
11 DITS.—Subject to subparagraph (C), if a medicare con-
12 tractor decides to conduct a post-payment audit of a
13 provider of services or supplier under this title, the con-
14 tractor shall provide the provider of services or supplier
15 with written notice (which may be in electronic form)
16 of the intent to conduct such an audit.

17 “(B) EXPLANATION OF FINDINGS FOR ALL AU-
18 DITS.—Subject to subparagraph (C), if a medicare con-
19 tractor audits a provider of services or supplier under
20 this title, the contractor shall—

21 “(i) give the provider of services or supplier a
22 full review and explanation of the findings of the
23 audit in a manner that is understandable to the
24 provider of services or supplier and permits the de-
25 velopment of an appropriate corrective action plan;

26 “(ii) inform the provider of services or supplier
27 of the appeal rights under this title as well as con-
28 sent settlement options (which are at the discretion
29 of the Secretary);

30 “(iii) give the provider of services or supplier
31 an opportunity to provide additional information to
32 the contractor; and

33 “(iv) take into account information provided,
34 on a timely basis, by the provider of services or
35 supplier under clause (iii).

36 “(C) EXCEPTION.—Subparagraphs (A) and (B)
37 shall not apply if the provision of notice or findings

1 would compromise pending law enforcement activities,
2 whether civil or criminal, or reveal findings of law en-
3 forcement-related audits.

4 “(8) STANDARD METHODOLOGY FOR PROBE SAM-
5 PLING.—The Secretary shall establish a standard method-
6 ology for medicare contractors to use in selecting a sample
7 of claims for review in the case of an abnormal billing pat-
8 tern.”.

9 (b) EFFECTIVE DATES AND DEADLINES.—

10 (1) USE OF REPAYMENT PLANS.—Section 1893(f)(1)
11 of the Social Security Act, as added by subsection (a), shall
12 apply to requests for repayment plans made after the date
13 of the enactment of this Act.

14 (2) LIMITATION ON RECOUPMENT.—Section
15 1893(f)(2) of the Social Security Act, as added by sub-
16 section (a), shall apply to actions taken after the date of
17 the enactment of this Act.

18 (3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of
19 the Social Security Act, as added by subsection (a), shall
20 apply to statistically valid random samples initiated after
21 the date that is 1 year after the date of the enactment of
22 this Act.

23 (4) PROVISION OF SUPPORTING DOCUMENTATION.—
24 Section 1893(f)(4) of the Social Security Act, as added by
25 subsection (a), shall take effect on the date of the enact-
26 ment of this Act.

27 (5) CONSENT SETTLEMENT.—Section 1893(f)(5) of
28 the Social Security Act, as added by subsection (a), shall
29 apply to consent settlements entered into after the date of
30 the enactment of this Act.

31 (6) NOTICE OF OVERUTILIZATION.—Not later than 1
32 year after the date of the enactment of this Act, the Sec-
33 retary shall first establish the process for notice of over-
34 utilization of billing codes under section 1893A(f)(6) of the
35 Social Security Act, as added by subsection (a).

36 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of the
37 Social Security Act, as added by subsection (a), shall apply

1 to audits initiated after the date of the enactment of this
2 Act.

3 (8) STANDARD FOR ABNORMAL BILLING PATTERNS.—
4 Not later than 1 year after the date of the enactment of
5 this Act, the Secretary shall first establish a standard
6 methodology for selection of sample claims for abnormal
7 billing patterns under section 1893(f)(8) of the Social Se-
8 curity Act, as added by subsection (a).

9 **SEC. 936. PROVIDER ENROLLMENT PROCESS; RIGHT OF**
10 **APPEAL.**

11 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is
12 amended—

13 (1) by adding at the end of the heading the following:

14 “; ENROLLMENT PROCESSES”; and

15 (2) by adding at the end the following new subsection:

16 “(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERV-
17 ICES AND SUPPLIERS.—

18 “(1) ENROLLMENT PROCESS.—

19 “(A) IN GENERAL.—The Secretary shall establish
20 by regulation a process for the enrollment of providers
21 of services and suppliers under this title.

22 “(B) DEADLINES.—The Secretary shall establish
23 by regulation procedures under which there are dead-
24 lines for actions on applications for enrollment (and, if
25 applicable, renewal of enrollment). The Secretary shall
26 monitor the performance of medicare administrative
27 contractors in meeting the deadlines established under
28 this subparagraph.

29 “(C) CONSULTATION BEFORE CHANGING PRO-
30 VIDER ENROLLMENT FORMS.—The Secretary shall con-
31 sult with providers of services and suppliers before
32 making changes in the provider enrollment forms re-
33 quired of such providers and suppliers to be eligible to
34 submit claims for which payment may be made under
35 this title.

36 “(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-
37 RENEWAL.—A provider of services or supplier whose appli-

1 cation to enroll (or, if applicable, to renew enrollment)
2 under this title is denied may have a hearing and judicial
3 review of such denial under the procedures that apply
4 under subsection (h)(1)(A) to a provider of services that is
5 dissatisfied with a determination by the Secretary.”.

6 (b) EFFECTIVE DATES.—

7 (1) ENROLLMENT PROCESS.—The Secretary shall pro-
8 vide for the establishment of the enrollment process under
9 section 1866(j)(1) of the Social Security Act, as added by
10 subsection (a)(2), within 6 months after the date of the en-
11 actment of this Act.

12 (2) CONSULTATION.—Section 1866(j)(1)(C) of the So-
13 cial Security Act, as added by subsection (a)(2), shall apply
14 with respect to changes in provider enrollment forms made
15 on or after January 1, 2004.

16 (3) HEARING RIGHTS.—Section 1866(j)(2) of the So-
17 cial Security Act, as added by subsection (a)(2), shall apply
18 to denials occurring on or after such date (not later than
19 1 year after the date of the enactment of this Act) as the
20 Secretary specifies.

21 **SEC. 937. PROCESS FOR CORRECTION OF MINOR ER-**
22 **RORS AND OMISSIONS WITHOUT PURSUING**
23 **APPEALS PROCESS.**

24 (a) CLAIMS.—The Secretary shall develop, in consultation
25 with appropriate medicare contractors (as defined in section
26 1889(g) of the Social Security Act, as inserted by section
27 301(a)(1)) and representatives of providers of services and sup-
28 pliers, a process whereby, in the case of minor errors or omis-
29 sions (as defined by the Secretary) that are detected in the sub-
30 mission of claims under the programs under title XVIII of such
31 Act, a provider of services or supplier is given an opportunity
32 to correct such an error or omission without the need to initiate
33 an appeal. Such process shall include the ability to resubmit
34 corrected claims.

35 (b) PERMITTING USE OF CORRECTED AND SUPPLE-
36 MENTARY DATA.—

1 (1) IN GENERAL.—Section 1886(d)(10)(D)(vi) (42
2 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after
3 subclause (II) at the end the following:

4 “Notwithstanding subclause (I), a hospital may submit, and the
5 Secretary may accept upon verification, data that corrects or
6 supplements the data described in such subclause without re-
7 gard to whether the corrected or supplementary data relate to
8 a cost report that has been settled.”.

9 (2) EFFECTIVE DATE.—The amendment made by
10 paragraph (1) shall apply to fiscal years beginning with fis-
11 cal year 2004.

12 (3) SUBMITTAL AND RESUBMITTAL OF APPLICATIONS
13 PERMITTED FOR FISCAL YEAR 2004.—

14 (A) IN GENERAL.—Notwithstanding any other
15 provision of law, a hospital may submit (or resubmit)
16 an application for a change described in section
17 1886(d)(10)(C)(i)(II) of the Social Security Act for fis-
18 cal year 2004 if the hospital demonstrates on a timely
19 basis to the satisfaction of the Secretary that the use
20 of corrected or supplementary data under the amend-
21 ment made by paragraph (1) would materially affect
22 the approval of such an application.

23 (B) APPLICATION OF BUDGET NEUTRALITY.—If
24 one or more hospital’s applications are approved as a
25 result of paragraph (1) and subparagraph (A) for fiscal
26 year 2004, the Secretary shall make a proportional ad-
27 justment in the standardized amounts determined
28 under section 1886(d)(3) of the Social Security Act (42
29 U.S.C. 1395ww(d)(3)) for fiscal year 2004 to assure
30 that approval of such applications does not result in
31 aggregate payments under section 1886(d) of such Act
32 that are greater or less than those that would otherwise
33 be made if paragraph (1) and subparagraph (A) did
34 not apply.

1 **SEC. 938. PRIOR DETERMINATION PROCESS FOR CER-**
2 **TAIN ITEMS AND SERVICES; ADVANCE BENE-**
3 **FICIARY NOTICES.**

4 (a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as
5 amended by sections 521 and 522 of BIPA and section
6 933(d)(2)(B), is further amended by adding at the end the fol-
7 lowing new subsection:

8 “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN
9 ITEMS AND SERVICES.—

10 “(1) ESTABLISHMENT OF PROCESS.—

11 “(A) IN GENERAL.—With respect to a medicare
12 administrative contractor that has a contract under
13 section 1874A that provides for making payments
14 under this title with respect to eligible items and serv-
15 ices described in subparagraph (C), the Secretary shall
16 establish a prior determination process that meets the
17 requirements of this subsection and that shall be ap-
18 plied by such contractor in the case of eligible request-
19 ers.

20 “(B) ELIGIBLE REQUESTER.—For purposes of
21 this subsection, each of the following shall be an eligi-
22 ble requester:

23 “(i) A physician, but only with respect to eligi-
24 ble items and services for which the physician may
25 be paid directly.

26 “(ii) An individual entitled to benefits under
27 this title, but only with respect to an item or serv-
28 ice for which the individual receives, from the phy-
29 sician who may be paid directly for the item or
30 service, an advance beneficiary notice under section
31 1879(a) that payment may not be made (or may no
32 longer be made) for the item or service under this
33 title.

34 “(C) ELIGIBLE ITEMS AND SERVICES.—For pur-
35 poses of this subsection and subject to paragraph (2),
36 eligible items and services are items and services which
37 are physicians’ services (as defined in paragraph (4)(A)

1 of section 1848(f) for purposes of calculating the sus-
2 tainable growth rate under such section).

3 “(2) SECRETARIAL FLEXIBILITY.—The Secretary shall
4 establish by regulation reasonable limits on the categories
5 of eligible items and services for which a prior determina-
6 tion of coverage may be requested under this subsection. In
7 establishing such limits, the Secretary may consider the
8 dollar amount involved with respect to the item or service,
9 administrative costs and burdens, and other relevant fac-
10 tors.

11 “(3) REQUEST FOR PRIOR DETERMINATION.—

12 “(A) IN GENERAL.—Subject to paragraph (2),
13 under the process established under this subsection an
14 eligible requester may submit to the contractor a re-
15 quest for a determination, before the furnishing of an
16 eligible item or service involved as to whether the item
17 or service is covered under this title consistent with the
18 applicable requirements of section 1862(a)(1)(A) (relat-
19 ing to medical necessity).

20 “(B) ACCOMPANYING DOCUMENTATION.—The Sec-
21 retary may require that the request be accompanied by
22 a description of the item or service, supporting docu-
23 mentation relating to the medical necessity for the item
24 or service, and any other appropriate documentation.
25 In the case of a request submitted by an eligible re-
26 quester who is described in paragraph (1)(B)(ii), the
27 Secretary may require that the request also be accom-
28 panied by a copy of the advance beneficiary notice in-
29 volved.

30 “(4) RESPONSE TO REQUEST.—

31 “(A) IN GENERAL.—Under such process, the con-
32 tractor shall provide the eligible requester with written
33 notice of a determination as to whether—

34 “(i) the item or service is so covered;

35 “(ii) the item or service is not so covered; or

36 “(iii) the contractor lacks sufficient informa-
37 tion to make a coverage determination.

1 If the contractor makes the determination described in
2 clause (iii), the contractor shall include in the notice a
3 description of the additional information required to
4 make the coverage determination.

5 “(B) DEADLINE TO RESPOND.—Such notice shall
6 be provided within the same time period as the time pe-
7 riod applicable to the contractor providing notice of ini-
8 tial determinations on a claim for benefits under sub-
9 section (a)(2)(A).

10 “(C) INFORMING BENEFICIARY IN CASE OF PHYSI-
11 CIAN REQUEST.—In the case of a request in which an
12 eligible requester is not the individual described in
13 paragraph (1)(B)(ii), the process shall provide that the
14 individual to whom the item or service is proposed to
15 be furnished shall be informed of any determination de-
16 scribed in clause (ii) (relating to a determination of
17 non-coverage) and the right (referred to in paragraph
18 (6)(B)) to obtain the item or service and have a claim
19 submitted for the item or service.

20 “(5) EFFECT OF DETERMINATIONS.—

21 “(A) BINDING NATURE OF POSITIVE DETERMINA-
22 TION.—If the contractor makes the determination de-
23 scribed in paragraph (4)(A)(i), such determination
24 shall be binding on the contractor in the absence of
25 fraud or evidence of misrepresentation of facts pre-
26 sented to the contractor.

27 “(B) NOTICE AND RIGHT TO REDETERMINATION
28 IN CASE OF A DENIAL.—

29 “(i) IN GENERAL.—If the contractor makes
30 the determination described in paragraph
31 (4)(A)(ii)—

32 “(I) the eligible requester has the right to
33 a redetermination by the contractor on the de-
34 termination that the item or service is not so
35 covered; and

36 “(II) the contractor shall include in notice
37 under paragraph (4)(A) a brief explanation of

1 the basis for the determination, including on
2 what national or local coverage or noncoverage
3 determination (if any) the determination is
4 based, and the right to such a redetermination.

5 “(ii) DEADLINE FOR REDETERMINATIONS.—
6 The contractor shall complete and provide notice of
7 such redetermination within the same time period
8 as the time period applicable to the contractor pro-
9 viding notice of redeterminations relating to a
10 claim for benefits under subsection (a)(3)(C)(ii).

11 “(6) LIMITATION ON FURTHER REVIEW.—

12 “(A) IN GENERAL.—Contractor determinations de-
13 scribed in paragraph (4)(A)(ii) or (4)(A)(iii) (and rede-
14 terminations made under paragraph (5)(B)), relating
15 to pre-service claims are not subject to further adminis-
16 trative appeal or judicial review under this section or
17 otherwise.

18 “(B) DECISION NOT TO SEEK PRIOR DETERMINA-
19 TION OR NEGATIVE DETERMINATION DOES NOT IMPACT
20 RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT,
21 OR APPEAL RIGHTS.—Nothing in this subsection shall
22 be construed as affecting the right of an individual
23 who—

24 “(i) decides not to seek a prior determination
25 under this subsection with respect to items or serv-
26 ices; or

27 “(ii) seeks such a determination and has re-
28 ceived a determination described in paragraph
29 (4)(A)(ii),

30 from receiving (and submitting a claim for) such items
31 services and from obtaining administrative or judicial
32 review respecting such claim under the other applicable
33 provisions of this section. Failure to seek a prior deter-
34 mination under this subsection with respect to items
35 and services shall not be taken into account in such ad-
36 ministrative or judicial review.

1 “(C) NO PRIOR DETERMINATION AFTER RECEIPT
2 OF SERVICES.—Once an individual is provided items
3 and services, there shall be no prior determination
4 under this subsection with respect to such items or
5 services.”.

6 (b) EFFECTIVE DATE; TRANSITION.—

7 (1) EFFECTIVE DATE.—The Secretary shall establish
8 the prior determination process under the amendment
9 made by subsection (a) in such a manner as to provide for
10 the acceptance of requests for determinations under such
11 process filed not later than 18 months after the date of the
12 enactment of this Act.

13 (2) TRANSITION.—During the period in which the
14 amendment made by subsection (a) has become effective
15 but contracts are not provided under section 1874A of the
16 Social Security Act with medicare administrative contrac-
17 tors, any reference in section 1869(g) of such Act (as
18 added by such amendment) to such a contractor is deemed
19 a reference to a fiscal intermediary or carrier with an
20 agreement under section 1816, or contract under section
21 1842, respectively, of such Act.

22 (3) LIMITATION ON APPLICATION TO SGR.—For pur-
23 poses of applying section 1848(f)(2)(D) of the Social Secu-
24 rity Act (42 U.S.C. 1395w-4(f)(2)(D)), the amendment
25 made by subsection (a) shall not be considered to be a
26 change in law or regulation.

27 (c) PROVISIONS RELATING TO ADVANCE BENEFICIARY
28 NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

29 (1) DATA COLLECTION.—The Secretary shall establish
30 a process for the collection of information on the instances
31 in which an advance beneficiary notice (as defined in para-
32 graph (5)) has been provided and on instances in which a
33 beneficiary indicates on such a notice that the beneficiary
34 does not intend to seek to have the item or service that is
35 the subject of the notice furnished.

36 (2) OUTREACH AND EDUCATION.—The Secretary shall
37 establish a program of outreach and education for bene-

1 ficiaries and providers of services and other persons on the
2 appropriate use of advance beneficiary notices and coverage
3 policies under the medicare program.

4 (3) GAO REPORT REPORT ON USE OF ADVANCE BENE-
5 FICIARY NOTICES.—Not later than 18 months after the
6 date on which section 1869(g) of the Social Security Act
7 (as added by subsection (a)) takes effect, the Comptroller
8 General of the United States shall submit to Congress a re-
9 port on the use of advance beneficiary notices under title
10 XVIII of such Act. Such report shall include information
11 concerning the providers of services and other persons that
12 have provided such notices and the response of beneficiaries
13 to such notices.

14 (4) GAO REPORT ON USE OF PRIOR DETERMINATION
15 PROCESS.—Not later than 18 months after the date on
16 which section 1869(g) of the Social Security Act (as added
17 by subsection (a)) takes effect, the Comptroller General of
18 the United States shall submit to Congress a report on the
19 use of the prior determination process under such section.
20 Such report shall include—

21 (A) information concerning the types of proce-
22 dures for which a prior determination has been sought,
23 determinations made under the process, and changes in
24 receipt of services resulting from the application of
25 such process; and

26 (B) an evaluation of whether the process was use-
27 ful for physicians (and other suppliers) and bene-
28 ficiaries, whether it was timely, and whether the
29 amount of information required was burdensome to
30 physicians and beneficiaries.

31 (5) ADVANCE BENEFICIARY NOTICE DEFINED.—In
32 this subsection, the term “advance beneficiary notice”
33 means a written notice provided under section 1879(a) of
34 the Social Security Act (42 U.S.C. 1395pp(a)) to an indi-
35 vidual entitled to benefits under part A or B of title XVIII
36 of such Act before items or services are furnished under
37 such part in cases where a provider of services or other

1 person that would furnish the item or service believes that
2 payment will not be made for some or all of such items or
3 services under such title.

4 **Subtitle V—Miscellaneous Provisions**

5 **SEC. 941. POLICY DEVELOPMENT REGARDING EVALUA-** 6 **TION AND MANAGEMENT (E & M) DOCU-** 7 **MENTATION GUIDELINES.**

8 (a) IN GENERAL.—The Secretary may not implement any
9 new documentation guidelines for, or clinical examples of, eval-
10 uation and management physician services under the title
11 XVIII of the Social Security Act on or after the date of the
12 enactment of this Act unless the Secretary—

13 (1) has developed the guidelines in collaboration with
14 practicing physicians (including both generalists and spe-
15 cialists) and provided for an assessment of the proposed
16 guidelines by the physician community;

17 (2) has established a plan that contains specific goals,
18 including a schedule, for improving the use of such guide-
19 lines;

20 (3) has conducted appropriate and representative pilot
21 projects under subsection (b) to test modifications to the
22 evaluation and management documentation guidelines;

23 (4) finds that the objectives described in subsection (c)
24 will be met in the implementation of such guidelines; and

25 (5) has established, and is implementing, a program to
26 educate physicians on the use of such guidelines and that
27 includes appropriate outreach.

28 The Secretary shall make changes to the manner in which ex-
29 isting evaluation and management documentation guidelines
30 are implemented to reduce paperwork burdens on physicians.

31 (b) PILOT PROJECTS TO TEST EVALUATION AND MAN-
32 AGEMENT DOCUMENTATION GUIDELINES.—

33 (1) IN GENERAL.—The Secretary shall conduct under
34 this subsection appropriate and representative pilot projects
35 to test new evaluation and management documentation
36 guidelines referred to in subsection (a).

1 (2) LENGTH AND CONSULTATION.—Each pilot project
2 under this subsection shall—

3 (A) be voluntary;

4 (B) be of sufficient length as determined by the
5 Secretary to allow for preparatory physician and medi-
6 care contractor education, analysis, and use and assess-
7 ment of potential evaluation and management guide-
8 lines; and

9 (C) be conducted, in development and throughout
10 the planning and operational stages of the project, in
11 consultation with practicing physicians (including both
12 generalists and specialists).

13 (3) RANGE OF PILOT PROJECTS.—Of the pilot projects
14 conducted under this subsection—

15 (A) at least one shall focus on a peer review meth-
16 od by physicians (not employed by a medicare con-
17 tractor) which evaluates medical record information for
18 claims submitted by physicians identified as statistical
19 outliers relative to definitions published in the Current
20 Procedures Terminology (CPT) code book of the Amer-
21 ican Medical Association;

22 (B) at least one shall focus on an alternative
23 method to detailed guidelines based on physician docu-
24 mentation of face to face encounter time with a patient;

25 (C) at least one shall be conducted for services
26 furnished in a rural area and at least one for services
27 furnished outside such an area; and

28 (D) at least one shall be conducted in a setting
29 where physicians bill under physicians' services in
30 teaching settings and at least one shall be conducted in
31 a setting other than a teaching setting.

32 (4) BANNING OF TARGETING OF PILOT PROJECT PAR-
33 TICIPANTS.—Data collected under this subsection shall not
34 be used as the basis for overpayment demands or post-pay-
35 ment audits. Such limitation applies only to claims filed as
36 part of the pilot project and lasts only for the duration of

1 the pilot project and only as long as the provider is a par-
2 ticipant in the pilot project.

3 (5) STUDY OF IMPACT.—Each pilot project shall ex-
4 amine the effect of the new evaluation and management
5 documentation guidelines on—

6 (A) different types of physician practices, includ-
7 ing those with fewer than 10 full-time-equivalent em-
8 ployees (including physicians); and

9 (B) the costs of physician compliance, including
10 education, implementation, auditing, and monitoring.

11 (6) PERIODIC REPORTS.—The Secretary shall submit
12 to Congress periodic reports on the pilot projects under this
13 subsection.

14 (c) OBJECTIVES FOR EVALUATION AND MANAGEMENT
15 GUIDELINES.—The objectives for modified evaluation and man-
16 agement documentation guidelines developed by the Secretary
17 shall be to—

18 (1) identify clinically relevant documentation needed to
19 code accurately and assess coding levels accurately;

20 (2) decrease the level of non-clinically pertinent and
21 burdensome documentation time and content in the physi-
22 cian's medical record;

23 (3) increase accuracy by reviewers; and

24 (4) educate both physicians and reviewers.

25 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOC-
26 UMENTATION FOR PHYSICIAN CLAIMS.—

27 (1) STUDY.—The Secretary shall carry out a study of
28 the matters described in paragraph (2).

29 (2) MATTERS DESCRIBED.—The matters referred to in
30 paragraph (1) are—

31 (A) the development of a simpler, alternative sys-
32 tem of requirements for documentation accompanying
33 claims for evaluation and management physician serv-
34 ices for which payment is made under title XVIII of
35 the Social Security Act; and

1 (B) consideration of systems other than current
2 coding and documentation requirements for payment
3 for such physician services.

4 (3) CONSULTATION WITH PRACTICING PHYSICIANS.—
5 In designing and carrying out the study under paragraph
6 (1), the Secretary shall consult with practicing physicians,
7 including physicians who are part of group practices and
8 including both generalists and specialists.

9 (4) APPLICATION OF HIPAA UNIFORM CODING RE-
10 QUIREMENTS.—In developing an alternative system under
11 paragraph (2), the Secretary shall consider requirements of
12 administrative simplification under part C of title XI of the
13 Social Security Act.

14 (5) REPORT TO CONGRESS.—(A) Not later than Octo-
15 ber 1, 2005, the Secretary shall submit to Congress a re-
16 port on the results of the study conducted under paragraph
17 (1).

18 (B) The Medicare Payment Advisory Commission shall
19 conduct an analysis of the results of the study included in
20 the report under subparagraph (A) and shall submit a re-
21 port on such analysis to Congress.

22 (e) STUDY ON APPROPRIATE CODING OF CERTAIN EX-
23 TENDED OFFICE VISITS.—The Secretary shall conduct a study
24 of the appropriateness of coding in cases of extended office vis-
25 its in which there is no diagnosis made. Not later than October
26 1, 2005, the Secretary shall submit a report to Congress on
27 such study and shall include recommendations on how to code
28 appropriately for such visits in a manner that takes into ac-
29 count the amount of time the physician spent with the patient.

30 (f) DEFINITIONS.—In this section—

31 (1) the term “rural area” has the meaning given that
32 term in section 1886(d)(2)(D) of the Social Security Act,
33 42 U.S.C. 1395ww(d)(2)(D); and

34 (2) the term “teaching settings” are those settings de-
35 scribed in section 415.150 of title 42, Code of Federal Reg-
36 ulations.

1 **SEC. 942. IMPROVEMENT IN OVERSIGHT OF TECH-**
2 **NOLOGY AND COVERAGE.**

3 (a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Sec-
4 tion 1868 (42 U.S.C. 1395ee), as amended by section 921(a),
5 is amended by adding at the end the following new subsection:

6 “(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

7 “(1) ESTABLISHMENT.—The Secretary shall establish
8 a Council for Technology and Innovation within the Cen-
9 ters for Medicare & Medicaid Services (in this section re-
10 ferred to as ‘CMS’).

11 “(2) COMPOSITION.—The Council shall be composed
12 of senior CMS staff and clinicians and shall be chaired by
13 the Executive Coordinator for Technology and Innovation
14 (appointed or designated under paragraph (4)).

15 “(3) DUTIES.—The Council shall coordinate the activi-
16 ties of coverage, coding, and payment processes under this
17 title with respect to new technologies and procedures, in-
18 cluding new drug therapies, and shall coordinate the ex-
19 change of information on new technologies between CMS
20 and other entities that make similar decisions.

21 “(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY
22 AND INNOVATION.—The Secretary shall appoint (or des-
23 ignate) a noncareer appointee (as defined in section
24 3132(a)(7) of title 5, United States Code) who shall serve
25 as the Executive Coordinator for Technology and Innova-
26 tion. Such executive coordinator shall report to the Admin-
27 istrator of CMS, shall chair the Council, shall oversee the
28 execution of its duties, and shall serve as a single point of
29 contact for outside groups and entities regarding the cov-
30 erage, coding, and payment processes under this title.”.

31 (b) METHODS FOR DETERMINING PAYMENT BASIS FOR
32 NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is
33 amended by adding at the end the following:

34 “(8)(A) The Secretary shall establish by regulation proce-
35 dures for determining the basis for, and amount of, payment
36 under this subsection for any clinical diagnostic laboratory test
37 with respect to which a new or substantially revised HCPCS

1 code is assigned on or after January 1, 2005 (in this para-
2 graph referred to as ‘new tests’).

3 “(B) Determinations under subparagraph (A) shall be
4 made only after the Secretary—

5 “(i) makes available to the public (through an Internet
6 site and other appropriate mechanisms) a list that includes
7 any such test for which establishment of a payment amount
8 under this subsection is being considered for a year;

9 “(ii) on the same day such list is made available,
10 causes to have published in the Federal Register notice of
11 a meeting to receive comments and recommendations (and
12 data on which recommendations are based) from the public
13 on the appropriate basis under this subsection for estab-
14 lishing payment amounts for the tests on such list;

15 “(iii) not less than 30 days after publication of such
16 notice convenes a meeting, that includes representatives of
17 officials of the Centers for Medicare & Medicaid Services
18 involved in determining payment amounts, to receive such
19 comments and recommendations (and data on which the
20 recommendations are based);

21 “(iv) taking into account the comments and rec-
22 ommendations (and accompanying data) received at such
23 meeting, develops and makes available to the public
24 (through an Internet site and other appropriate mecha-
25 nisms) a list of proposed determinations with respect to the
26 appropriate basis for establishing a payment amount under
27 this subsection for each such code, together with an expla-
28 nation of the reasons for each such determination, the data
29 on which the determinations are based, and a request for
30 public written comments on the proposed determination;
31 and

32 “(v) taking into account the comments received during
33 the public comment period, develops and makes available to
34 the public (through an Internet site and other appropriate
35 mechanisms) a list of final determinations of the payment
36 amounts for such tests under this subsection, together with
37 the rationale for each such determination, the data on

1 which the determinations are based, and responses to com-
2 ments and suggestions received from the public.

3 “(C) Under the procedures established pursuant to sub-
4 paragraph (A), the Secretary shall—

5 “(i) set forth the criteria for making determinations
6 under subparagraph (A); and

7 “(ii) make available to the public the data (other than
8 proprietary data) considered in making such determina-
9 tions.

10 “(D) The Secretary may convene such further public meet-
11 ings to receive public comments on payment amounts for new
12 tests under this subsection as the Secretary deems appropriate.

13 “(E) For purposes of this paragraph:

14 “(i) The term ‘HCPCS’ refers to the Health Care Pro-
15 cedure Coding System.

16 “(ii) A code shall be considered to be ‘substantially re-
17 vised’ if there is a substantive change to the definition of
18 the test or procedure to which the code applies (such as a
19 new analyte or a new methodology for measuring an exist-
20 ing analyte-specific test).”.

21 (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA
22 COLLECTION FOR USE IN THE MEDICARE INPATIENT PAY-
23 MENT SYSTEM.—

24 (1) STUDY.—The Comptroller General of the United
25 States shall conduct a study that analyzes which external
26 data can be collected in a shorter time frame by the Cen-
27 ters for Medicare & Medicaid Services for use in computing
28 payments for inpatient hospital services. The study may in-
29 clude an evaluation of the feasibility and appropriateness of
30 using of quarterly samples or special surveys or any other
31 methods. The study shall include an analysis of whether
32 other executive agencies, such as the Bureau of Labor Sta-
33 tistics in the Department of Commerce, are best suited to
34 collect this information.

35 (2) REPORT.—By not later than October 1, 2004, the
36 Comptroller General shall submit a report to Congress on
37 the study under paragraph (1).

1 **SEC. 943. TREATMENT OF HOSPITALS FOR CERTAIN**
2 **SERVICES UNDER MEDICARE SECONDARY**
3 **PAYOR (MSP) PROVISIONS.**

4 (a) IN GENERAL.—The Secretary shall not require a hos-
5 pital (including a critical access hospital) to ask questions (or
6 obtain information) relating to the application of section
7 1862(b) of the Social Security Act (relating to medicare sec-
8 ondary payor provisions) in the case of reference laboratory
9 services described in subsection (b), if the Secretary does not
10 impose such requirement in the case of such services furnished
11 by an independent laboratory.

12 (b) REFERENCE LABORATORY SERVICES DESCRIBED.—
13 Reference laboratory services described in this subsection are
14 clinical laboratory diagnostic tests (or the interpretation of
15 such tests, or both) furnished without a face-to-face encounter
16 between the individual entitled to benefits under part A or en-
17 rolled under part B, or both, and the hospital involved and in
18 which the hospital submits a claim only for such test or inter-
19 pretation.

20 **SEC. 944. EMTALA IMPROVEMENTS.**

21 (a) PAYMENT FOR EMTALA-MANDATED SCREENING AND
22 STABILIZATION SERVICES.—

23 (1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is
24 amended by inserting after subsection (c) the following new
25 subsection:

26 “(d) For purposes of subsection (a)(1)(A), in the case of
27 any item or service that is required to be provided pursuant to
28 section 1867 to an individual who is entitled to benefits under
29 this title, determinations as to whether the item or service is
30 reasonable and necessary shall be made on the basis of the in-
31 formation available to the treating physician or practitioner (in-
32 cluding the patient’s presenting symptoms or complaint) at the
33 time the item or service was ordered or furnished by the physi-
34 cian or practitioner (and not on the patient’s principal diag-
35 nosis). When making such determinations with respect to such
36 an item or service, the Secretary shall not consider the fre-

1 quency with which the item or service was provided to the pa-
2 tient before or after the time of the admission or visit.”.

3 (2) EFFECTIVE DATE.—The amendment made by
4 paragraph (1) shall apply to items and services furnished
5 on or after January 1, 2004.

6 (b) NOTIFICATION OF PROVIDERS WHEN EMTALA IN-
7 VESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C.
8 1395dd(d)) is amended by adding at the end the following new
9 paragraph:

10 “(4) NOTICE UPON CLOSING AN INVESTIGATION.—The
11 Secretary shall establish a procedure to notify hospitals and
12 physicians when an investigation under this section is
13 closed.”.

14 (c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN
15 EMTALA CASES INVOLVING TERMINATION OF PARTICIPA-
16 TION.—

17 (1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C.
18 1395dd(d)(3)) is amended—

19 (A) in the first sentence, by inserting “or in termi-
20 nating a hospital’s participation under this title” after
21 “in imposing sanctions under paragraph (1)”; and

22 (B) by adding at the end the following new sen-
23 tences: “Except in the case in which a delay would
24 jeopardize the health or safety of individuals, the Sec-
25 retary shall also request such a review before making
26 a compliance determination as part of the process of
27 terminating a hospital’s participation under this title
28 for violations related to the appropriateness of a med-
29 ical screening examination, stabilizing treatment, or an
30 appropriate transfer as required by this section, and
31 shall provide a period of 5 days for such review. The
32 Secretary shall provide a copy of the organization’s re-
33 port to the hospital or physician consistent with con-
34 fidentiality requirements imposed on the organization
35 under such part B.”.

1 (2) EFFECTIVE DATE.—The amendments made by
2 paragraph (1) shall apply to terminations of participation
3 initiated on or after the date of the enactment of this Act.

4 **SEC. 945. EMERGENCY MEDICAL TREATMENT AND AC-**
5 **TIVE LABOR ACT (EMTALA) TECHNICAL AD-**
6 **VISORY GROUP.**

7 (a) ESTABLISHMENT.—The Secretary shall establish a
8 Technical Advisory Group (in this section referred to as the
9 “Advisory Group”) to review issues related to the Emergency
10 Medical Treatment and Labor Act (EMTALA) and its imple-
11 mentation. In this section, the term “EMTALA” refers to the
12 provisions of section 1867 of the Social Security Act (42 U.S.C.
13 1395dd).

14 (b) MEMBERSHIP.—The Advisory Group shall be com-
15 posed of 19 members, including the Administrator of the Cen-
16 ters for Medicare & Medicaid Services and the Inspector Gen-
17 eral of the Department of Health and Human Services and of
18 which—

19 (1) 4 shall be representatives of hospitals, including at
20 least one public hospital, that have experience with the ap-
21 plication of EMTALA and at least 2 of which have not
22 been cited for EMTALA violations;

23 (2) 7 shall be practicing physicians drawn from the
24 fields of emergency medicine, cardiology or cardiothoracic
25 surgery, orthopedic surgery, neurosurgery, pediatrics or a
26 pediatric subspecialty, obstetrics-gynecology, and psychi-
27 atry, with not more than one physician from any particular
28 field;

29 (3) 2 shall represent patients;

30 (4) 2 shall be staff involved in EMTALA investiga-
31 tions from different regional offices of the Centers for
32 Medicare & Medicaid Services; and

33 (5) 1 shall be from a State survey office involved in
34 EMTALA investigations and 1 shall be from a peer review
35 organization, both of whom shall be from areas other than
36 the regions represented under paragraph (4).

1 In selecting members described in paragraphs (1) through (3),
2 the Secretary shall consider qualified individuals nominated by
3 organizations representing providers and patients.

4 (c) GENERAL RESPONSIBILITIES.—The Advisory Group—

5 (1) shall review EMTALA regulations;

6 (2) may provide advice and recommendations to the
7 Secretary with respect to those regulations and their appli-
8 cation to hospitals and physicians;

9 (3) shall solicit comments and recommendations from
10 hospitals, physicians, and the public regarding the imple-
11 mentation of such regulations; and

12 (4) may disseminate information on the application of
13 such regulations to hospitals, physicians, and the public.

14 (d) ADMINISTRATIVE MATTERS.—

15 (1) CHAIRPERSON.—The members of the Advisory
16 Group shall elect a member to serve as chairperson of the
17 Advisory Group for the life of the Advisory Group.

18 (2) MEETINGS.—The Advisory Group shall first meet
19 at the direction of the Secretary. The Advisory Group shall
20 then meet twice per year and at such other times as the
21 Advisory Group may provide.

22 (e) TERMINATION.—The Advisory Group shall terminate
23 30 months after the date of its first meeting.

24 (f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Sec-
25 retary shall establish the Advisory Group notwithstanding any
26 limitation that may apply to the number of advisory committees
27 that may be established (within the Department of Health and
28 Human Services or otherwise).

29 **SEC. 946. AUTHORIZING USE OF ARRANGEMENTS TO**
30 **PROVIDE CORE HOSPICE SERVICES IN CER-**
31 **TAIN CIRCUMSTANCES.**

32 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.
33 1395x(dd)(5)) is amended by adding at the end the following:

34 “(D) In extraordinary, exigent, or other non-routine cir-
35 cumstances, such as unanticipated periods of high patient
36 loads, staffing shortages due to illness or other events, or tem-
37 porary travel of a patient outside a hospice program’s service

1 area, a hospice program may enter into arrangements with an-
2 other hospice program for the provision by that other program
3 of services described in paragraph (2)(A)(ii)(I). The provisions
4 of paragraph (2)(A)(ii)(II) shall apply with respect to the serv-
5 ices provided under such arrangements.

6 “(E) A hospice program may provide services described in
7 paragraph (1)(A) other than directly by the program if the
8 services are highly specialized services of a registered profes-
9 sional nurse and are provided non-routinely and so infrequently
10 so that the provision of such services directly would be imprac-
11 ticable and prohibitively expensive.”.

12 (b) CONFORMING PAYMENT PROVISION.—Section 1814(i)
13 (42 U.S.C. 1395f(i)) is amended by adding at the end the fol-
14 lowing new paragraph:

15 “(4) In the case of hospice care provided by a hospice pro-
16 gram under arrangements under section 1861(dd)(5)(D) made
17 by another hospice program, the hospice program that made
18 the arrangements shall bill and be paid for the hospice care.”.

19 (c) EFFECTIVE DATE.—The amendments made by this
20 section shall apply to hospice care provided on or after the date
21 of the enactment of this Act.

22 **SEC. 947. APPLICATION OF OSHA BLOODBORNE PATHO-**
23 **GENS STANDARD TO CERTAIN HOSPITALS.**

24 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is
25 amended—

26 (1) in subsection (a)(1)—

27 (A) in subparagraph (R), by striking “and” at the
28 end;

29 (B) in subparagraph (S), by striking the period at
30 the end and inserting “, and”; and

31 (C) by inserting after subparagraph (S) the fol-
32 lowing new subparagraph:

33 “(T) in the case of hospitals that are not otherwise
34 subject to the Occupational Safety and Health Act of 1970,
35 to comply with the Bloodborne Pathogens standard under
36 section 1910.1030 of title 29 of the Code of Federal Regu-
37 lations (or as subsequently redesignated).”; and

1 (2) by adding at the end of subsection (b) the fol-
2 lowing new paragraph:

3 “(4)(A) A hospital that fails to comply with the require-
4 ment of subsection (a)(1)(T) (relating to the Bloodborne
5 Pathogens standard) is subject to a civil money penalty in an
6 amount described in subparagraph (B), but is not subject to
7 termination of an agreement under this section.

8 “(B) The amount referred to in subparagraph (A) is an
9 amount that is similar to the amount of civil penalties that may
10 be imposed under section 17 of the Occupational Safety and
11 Health Act of 1970 for a violation of the Bloodborne Pathogens
12 standard referred to in subsection (a)(1)(T) by a hospital that
13 is subject to the provisions of such Act.

14 “(C) A civil money penalty under this paragraph shall be
15 imposed and collected in the same manner as civil money pen-
16 alties under subsection (a) of section 1128A are imposed and
17 collected under that section.”.

18 (b) EFFECTIVE DATE.—The amendments made by this
19 subsection (a) shall apply to hospitals as of July 1, 2004.

20 **SEC. 948. BIPA-RELATED TECHNICAL AMENDMENTS AND**
21 **CORRECTIONS.**

22 (a) TECHNICAL AMENDMENTS RELATING TO ADVISORY
23 COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of
24 section 1114 (42 U.S.C. 1314)—

25 (A) is transferred to section 1862 and added at the
26 end of such section; and

27 (B) is redesignated as subsection (j).

28 (2) Section 1862 (42 U.S.C. 1395y) is amended—

29 (A) in the last sentence of subsection (a), by striking
30 “established under section 1114(f)”; and

31 (B) in subsection (j), as so transferred and
32 redesignated—

33 (i) by striking “under subsection (f)”; and

34 (ii) by striking “section 1862(a)(1)” and inserting
35 “subsection (a)(1)”.

1 (b) TERMINOLOGY CORRECTIONS.—(1) Section
2 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by
3 section 521 of BIPA, is amended—

4 (A) in subclause (III), by striking “policy” and insert-
5 ing “determination”; and

6 (B) in subclause (IV), by striking “medical review
7 policies” and inserting “coverage determinations”.

8 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C))
9 is amended by striking “policy” and “POLICY” and inserting
10 “determination” each place it appears and “DETERMINATION”,
11 respectively.

12 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42
13 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is
14 amended—

15 (1) in subparagraph (A)(iv), by striking “subclause
16 (I), (II), or (III)” and inserting “clause (i), (ii), or (iii)”;

17 (2) in subparagraph (B), by striking “clause (i)(IV)”
18 and “clause (i)(III)” and inserting “subparagraph (A)(iv)”
19 and “subparagraph (A)(iii)”, respectively; and

20 (3) in subparagraph (C), by striking “clause (i)”,
21 “subclause (IV)” and “subparagraph (A)” and inserting
22 “subparagraph (A)”, “clause (iv)” and “paragraph
23 (1)(A)”, respectively each place it appears.

24 (d) OTHER CORRECTIONS.—Effective as if included in the
25 enactment of section 521(c) of BIPA, section 1154(e) (42
26 U.S.C. 1320c-3(e)) is amended by striking paragraph (5).

27 (e) EFFECTIVE DATE.—Except as otherwise provided, the
28 amendments made by this section shall be effective as if in-
29 cluded in the enactment of BIPA.

30 **SEC. 949. CONFORMING AUTHORITY TO WAIVE A PRO-**
31 **GRAM EXCLUSION.**

32 The first sentence of section 1128(c)(3)(B) (42 U.S.C.
33 1320a-7(c)(3)(B)) is amended to read as follows: “Subject to
34 subparagraph (G), in the case of an exclusion under subsection
35 (a), the minimum period of exclusion shall be not less than five
36 years, except that, upon the request of the administrator of a
37 Federal health care program (as defined in section 1128B(f))

1 who determines that the exclusion would impose a hardship on
2 individuals entitled to benefits under part A of title XVIII or
3 enrolled under part B of such title, or both, the Secretary may
4 waive the exclusion under subsection (a)(1), (a)(3), or (a)(4)
5 with respect to that program in the case of an individual or en-
6 tity that is the sole community physician or sole source of es-
7 sential specialized services in a community.”.

8 **SEC. 950. TREATMENT OF CERTAIN DENTAL CLAIMS.**

9 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is
10 amended by adding after subsection (g) the following new sub-
11 section:

12 “(h)(1) Subject to paragraph (2), a group health plan (as
13 defined in subsection (a)(1)(A)(v)) providing supplemental or
14 secondary coverage to individuals also entitled to services under
15 this title shall not require a medicare claims determination
16 under this title for dental benefits specifically excluded under
17 subsection (a)(12) as a condition of making a claims deter-
18 mination for such benefits under the group health plan.

19 “(2) A group health plan may require a claims determina-
20 tion under this title in cases involving or appearing to involve
21 inpatient dental hospital services or dental services expressly
22 covered under this title pursuant to actions taken by the Sec-
23 retary.”.

24 (b) EFFECTIVE DATE.—The amendment made by sub-
25 section (a) shall take effect on the date that is 60 days after
26 the date of the enactment of this Act.

27 **SEC. 951. FURNISHING HOSPITALS WITH INFORMATION**
28 **TO COMPUTE DSH FORMULA.**

29 Beginning not later than 1 year after the date of the en-
30 actment of this Act, the Secretary shall furnish to subsection
31 (d) hospitals (as defined in section 1886(d)(1)(B) of the Social
32 Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary
33 for such hospitals to compute the number of patient days de-
34 scribed in subclause (II) of section 1886(d)(5)(F)(vi) of the So-
35 cial Security Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) used in
36 computing the disproportionate patient percentage under such
37 section for that hospital. Such data shall also be furnished to

1 other hospitals which would qualify for additional payments
2 under part A of title XVIII of the Social Security Act on the
3 basis of such data.

4 **SEC. 952. REVISIONS TO REASSIGNMENT PROVISIONS.**

5 (a) IN GENERAL.—Section 1842(b)(6)(A) (42 U.S.C.
6 1395u(b)(6)(A)) is amended by striking “or (ii) (where the
7 service was provided in a hospital, critical access hospital, clinic,
8 or other facility) to the facility in which the service was provided
9 if there is a contractual arrangement between such physician
10 or other person and such facility under which such facility
11 submits the bill for such service,” and inserting “or (ii) where
12 the service was provided under a contractual arrangement between
13 such physician or other person and an entity (as defined
14 by the Secretary), to the entity if, under the contractual arrangement,
15 the entity submits the bill for the service and the contractual arrangement
16 meets such other program integrity and other safeguards as the Secretary
17 may determine to be appropriate,”.

18
19 (b) CONFORMING AMENDMENT.—The second sentence of
20 section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by
21 striking “except to an employer or facility” and inserting “except
22 to an employer, entity, or other person”.

23 (c) EFFECTIVE DATE.—The amendments made by section
24 shall apply to payments made on or after the date that is one
25 year after the date of the enactment of this Act.

26 **SEC. 953. OTHER PROVISIONS.**

27 (a) GAO REPORTS ON THE PHYSICIAN COMPENSATION.—

28 (1) SUSTAINABLE GROWTH RATE AND UPDATES.—

29 Not later than 6 months after the date of the enactment
30 of this Act, the Comptroller General of the United States
31 shall submit to Congress a report on the appropriateness
32 of the updates in the conversion factor under subsection
33 (d)(3) of section 1848 of the Social Security Act (42
34 U.S.C. 1395w-4), including the appropriateness of the sustainable
35 growth rate formula under subsection (f) of such
36 section for 2002 and succeeding years. Such report shall
37 examine the stability and predictability of such updates and

1 rate and alternatives for the use of such rate in the up-
2 dates.

3 (2) PHYSICIAN COMPENSATION GENERALLY.—Not
4 later than 12 months after the date of the enactment of
5 this Act, the Comptroller General shall submit to Congress
6 a report on all aspects of physician compensation for serv-
7 ices furnished under title XVIII of the Social Security Act,
8 and how those aspects interact and the effect on appro-
9 priate compensation for physician services. Such report
10 shall review alternatives for the physician fee schedule
11 under section 1848 of such title (42 U.S.C. 1395w–4).

12 (b) ANNUAL PUBLICATION OF LIST OF NATIONAL COV-
13 ERAGE DETERMINATIONS.—The Secretary shall provide, in an
14 appropriate annual publication available to the public, a list of
15 national coverage determinations made under title XVIII of the
16 Social Security Act in the previous year and information on
17 how to get more information with respect to such determina-
18 tions.

19 (c) GAO REPORT ON FLEXIBILITY IN APPLYING HOME
20 HEALTH CONDITIONS OF PARTICIPATION TO PATIENTS WHO
21 ARE NOT MEDICARE BENEFICIARIES.—Not later than 6
22 months after the date of the enactment of this Act, the Comp-
23 troller General of the United States shall submit to Congress
24 a report on the implications if there were flexibility in the ap-
25 plication of the medicare conditions of participation for home
26 health agencies with respect to groups or types of patients who
27 are not medicare beneficiaries. The report shall include an
28 analysis of the potential impact of such flexible application on
29 clinical operations and the recipients of such services and an
30 analysis of methods for monitoring the quality of care provided
31 to such recipients.

32 (d) OIG REPORT ON NOTICES RELATING TO USE OF
33 HOSPITAL LIFETIME RESERVE DAYS.—Not later than 1 year
34 after the date of the enactment of this Act, the Inspector Gen-
35 eral of the Department of Health and Human Services shall
36 submit a report to Congress on—

- 1 (1) the extent to which hospitals provide notice to
- 2 medicare beneficiaries in accordance with applicable re-
- 3 quirements before they use the 60 lifetime reserve days de-
- 4 scribed in section 1812(a)(1) of the Social Security Act (42
- 5 U.S.C. 1395d(a)(1)); and
- 6 (2) the appropriateness and feasibility of hospitals pro-
- 7 viding a notice to such beneficiaries before they completely
- 8 exhaust such lifetime reserve days.